Individual Medical Form

Health History and Medical Permission Form

One form per person (Must have a copy of this for every boy and man when you register at event/camp.

Please print

Today's Date _____

Name _____
Address _____
City _____
State _____ Zip _____
Phone ( ) _____
Date of Birth _____
Grade _____
Ranger Outpost # _____

NOTIFY IN AN EMERGENCY:

Name _____
Address _____
City _____
State _____ Zip _____
Emergency Phone ( ) _____
Relationship _____
Parent Email Address _____
Church Name _____ City _____ State___

Have you ever been treated for any of the following? If yes, check the box.

- ❑ Heart disease
- ❑ Seizures
- ❑ High blood pressure
- ❑ Asthma
- ❑ Bronchitis
- ❑ Diabetes

Please identify any allergies, physical impairments or limitations: _____
_____
_____

Please list any medications being taken:
_____
_____

Please provide additional information about any items (checked Yes) to left.
_____
_____
_____
_____
_____

Date of last Tetanus booster _____
(month and year)

Do you wear: (If yes, check the box.)

- ❑ Contacts
- ❑ Glasses
- ❑ Dental appliance

IN THE EVENT HOSPITALIZATION IS NEEDED, PLEASE FILL IN BELOW

Name of Insured: _____
(POLICY HOLDER)
MEDICAL / HOSPITAL INSURANCE COMPANY: _____
POLICY OR CERTIFICATE NUMBER: _____
EMPLOYER: _____ EMPLOYER'S GROUP: _____
NUMBER: _____ SUBSCRIBER'S DATE OF BIRTH: _____

In case of emergency, I herby give permission to the physician to render treatment. Should the physician deem necessary, I authorize hospitalization, anesthesia, surgery or injection of medication.

_____ _____
Signature (Parent, if minor) *Date*

Name of person to contact (Commander or Adult) on premises for information:

_____