

Southpointe Christian Center Royal Rangers Medical Form

Instructions: Please complete a copy of this form for each individual registering.

Full Name _____ Father/Guardian _____
 Birthday ___/___/___ Grade _____ Cell Phone () ___-____ Work Phone () ___-____
 Address _____ Mother/Guardian _____
 City,St,Zip _____ Cell Phone () ___-____ Work Phone () ___-____
 Phone Numbers() ___-____ () ___-____
 1) Emergency Contact _____ Relation _____ Phone () ___-____
 2) Emergency Contact _____ Relation _____ Phone () ___-____

HEALTH HISTORY Check either Yes or No. If Yes is checked please explain under "Remarks and Medical Facts".

Sinus Condition <input type="radio"/> YES <input type="radio"/> NO	Shortness of Breath <input type="radio"/> YES <input type="radio"/> NO	Exposed to Infections: Disease past 3 weeks <input type="radio"/> YES <input type="radio"/> NO
Ear Problem <input type="radio"/> YES <input type="radio"/> NO	Skin Infection <input type="radio"/> YES <input type="radio"/> NO	Hepatitis past 6 months <input type="radio"/> YES <input type="radio"/> NO
Lung Problem <input type="radio"/> YES <input type="radio"/> NO	Hearing Difficulty <input type="radio"/> YES <input type="radio"/> NO	Any disorder preventing strenuous activity? <input type="radio"/> YES <input type="radio"/> NO
Heart Trouble <input type="radio"/> YES <input type="radio"/> NO	Bad Eyesight <input type="radio"/> YES <input type="radio"/> NO	Taking prescription medicine? <input type="radio"/> YES <input type="radio"/> NO
High Blood Pressure <input type="radio"/> YES <input type="radio"/> NO	Wear Eye Glasses <input type="radio"/> YES <input type="radio"/> NO	Any Reaction to drugs or medicine of any type? <input type="radio"/> YES <input type="radio"/> NO
Allergy-Asthma <input type="radio"/> YES <input type="radio"/> NO	Wear Contact Lenses <input type="radio"/> YES <input type="radio"/> NO	Get nervous or upset easily? Homesick? <input type="radio"/> YES <input type="radio"/> NO
Fainting or Dizzy Spells <input type="radio"/> YES <input type="radio"/> NO	Any Medical Care within Past Year? <input type="radio"/> YES <input type="radio"/> NO	Sleep Walker? <input type="radio"/> YES <input type="radio"/> NO
Diabetes <input type="radio"/> YES <input type="radio"/> NO	Any Surgeries within Past Year? <input type="radio"/> YES <input type="radio"/> NO	
Appendix Removed <input type="radio"/> YES <input type="radio"/> NO	Special Diet Required? <input type="radio"/> YES <input type="radio"/> NO	
Dental Appliances <input type="radio"/> YES <input type="radio"/> NO		

Drug Allergies _____ Last Tetanus Shot ___/___/___
 Currently taking the following medications _____ Swimming Level (Please Circle):
 Plant, Insect or Animal Allergies? _____ Non Swimmer, Beginner, Intermediate, Advanced
 Remarks and Medical Facts: _____ **Doctor and Insurance Info**
 _____ () ___-____
 _____ Doctor's Name & Phone
 _____ () ___-____
 _____ Insurance Company & Phone
 _____ Policy ID# and Group Number
 _____ Subscriber's Name & Relationship

I GIVE PERMISSION TO THE LICENSE PHYSICIAN AND HOSPITAL AS WELL AS ANY DENTIST SELECDED BY THE ROYAL RANGER LEADER IN CHARGE TO HOSPITALIZE, SECURE PROPER TREATMENT, AND ORDER INJECTION, ANESTHESIA, DENTAL CARE, OR SURGERY TO MY SON. (TO BE USED ONLY AFTER REASONABLE ATTEMPTS TO REACH A PARENT OR GARDIAN HAS BEEN MADE.)

PARENT/GARDIAN SIGNATURE: _____

PRINTED NAME: _____

DATE: _____