Royal Rangers Medical Release Form

Royal Rangers Medical History/ Release Form -- Chartering Dates Sep, 20___ thru Aug, 20___

All information on this form is private & shall remain confidential

Name: _____ Birth Date: _____/____ /_____ Age:____ Grade:_____

Home Address:_____ City: _____ State:___Zip:_____

Email address:_____ OP#_____ Division_____ Church_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

1.) Emergency Contact: _____ Relation: _____ Phone:_____

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

	Yes	No		Yes	No		Yes	No
Sinus Condition			Shortness of Breath			Exposed to infections:		
Ear Problem			Skin Infection			Disease past 3 weeks		
Lung Problem			Hearing Difficulty			Hepatitis past 6 mths		
Heart Trouble			Bad Eyesight			Any Disorder preventing strenuous activity		
High Blood Pressure			Wear Eye Glasses			Taking prescription medicine		
Allergy-Asthma			Wear Contact Lenses			Any negative reaction to drugs or medicine of any type		
Fainting or Dizzy Spells			Medical Care in last year			Nervous / upset easily		
Diabetes			Surgery in last year			Home sick		
Appendix Removed			Special Diet Required			Sleep walker		
Dental Appliances								

Remarks and Medical Facts (Allergies/Dietary Needs/Etc.):

Swimming Ability (please check one):

Non-Swimmer ❑ Beginner ❑

Intermediate ❑ Advanced ❑

Life Guard ❑

In the event medical care is needed for the child named above, I hereby give authorization/permission to the Medical Staff and/or the Person In Charge, or their designee, to use their discretion in rendering care and treatment to the child. I hereby authorize the Medical Staff and/or the Person In Charge, or their designee, to use their discretion in contacting a properly licensed paramedic, physician, or emergency health care center (hospital, or clinic, or 911) and to follow their instructions. I also authorize the Medical Staff and/or Person In Charge, or their designee, to authorize/order emergency medical services for my child, including emergency rescue services, ambulance transport, hospitalization, surgery, anesthesia, and medication.

Last Tetanus Shot____ /_____/_____

Insurance Co.: _____

Policy ID/Group #: _____

Relationship: _____

Parent □ *or* **Guardian** □ *(please check one)*

Signature:_____

Printed Name:_____

Date:_____

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this ___ day of _____, 20___, by _____. (S)He is personally known to me or has produced _____ as identification.

Signature of Notary **Print Name of Notary** **Notary Stamp/Seal**