

# 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