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**