

Southern Pacific Latin American District 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 Number\$ () ____-____ () ____-____
 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 Contact Lenses <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	Any Medical Care within Past Year? <input type="radio"/> YES <input type="radio"/> NO	Nervous or upset easily <input type="radio"/> YES <input type="radio"/> NO
Fainting or Dizzy Spells <input type="radio"/> YES <input type="radio"/> NO	Any Surgeries 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	Special Diet Required? <input type="radio"/> YES <input type="radio"/> NO	
Appendix Removed <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
 Food Allergies or Special Diet? _____ Policy and/or Group Number

 _____ Subscriber's Name & Relationship
 Additional Remarks: