



Medical Treatment Permission Form

I give my son, _____ permission to

Attend the District _____ on _____

Parent/Guardian Date

_____ Name
_____ Address/City/St
Phone _____

AUTHORIZATION FOR MEDICAL TREATMENT

In the event my son is injured or requires medical treatment while in the care or supervision of the Royal Rangers, or any of its officers or leaders, I thereby grant my permission to administer first aid for his relief. If it is not practical to return him to us or to receive our instruction for his care, consent is hereby given to admit him to any hospital; consent is also given to any licensed physician and/or medical specialist to administer necessary medical treatment.

Authorization is also given for such other measures or procedures as may be required. I hereby agree to reimburse Royal Rangers for any expenses incurred in the care of my son should any medical treatment be necessary.

Parent/Guardian Signature Date

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):
 Non Swimmer, Beginner, Intermediate, Advanced

Plant, Insect or Animal Allergies? _____

Remarks and Medical Facts: _____ Doctor and Insurance Info
 _____ () ____-____
 _____ Doctor's Name & Phone
 _____ () ____-____
 _____ Insurance Company & Phone
 _____ Policy and/or Group Number
 _____ Subscriber's Name & Relationship

Food Allergies or Special Diet? _____

Additional Remarks: _____