

Royal Rangers Medical History / Release Form

Camper's Name _____

OP# / Church / City _____

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|---|---|
| <p>In case of emergency, please notify:</p> <p>_____</p> <p style="text-align: center;">Name</p> <p>_____</p> <p style="text-align: center;">Daytime Contact Number</p> <p>_____</p> <p style="text-align: center;">Evening Contact Number</p> <p>_____</p> <p style="text-align: center;">Health Insurance Company's Phone Number</p> | <p>Insurance Information:</p> <p>_____</p> <p style="text-align: center;">Health Insurance Company</p> <p>_____</p> <p style="text-align: center;">Policy Number</p> <p>_____</p> <p style="text-align: center;">Certificate Number</p> <p>_____</p> <p style="text-align: center;">Effective Date of Coverage</p> |
|---|---|

GENERAL INFORMATION:

A complete health history must be completed by each applicant for participation at any North Texas District Royal Rangers event.

Minors (under age 18) must have a parent or guardian's signature verifying the health history information.

The North Texas District Royal Rangers has the prerogative to accept or reject any person based upon his medical health.

Give the date of your latest tetanus shot or booster: ____/____/____

Birth Date: ____/____/____

Height: _____ Weight: _____

Remarks: _____

HEALTH HISTORY:

To be completed by the applicant (if 18 or older) or by a parent/guardian if the applicant is a minor (under age 18). Has the applicant ever experienced any disorders of the following?

Check either Y for Yes or N for No.

If "Yes" explain under "Remarks and medical facts."

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| <u>Allergies or Asthma</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Hypertension</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Allergies to Ant or Insect Bites or Bee Stings?</u> <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Bleeding or Clotting</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Kidney or Bed Wetting</u> <input type="checkbox"/> Y <input type="checkbox"/> N | _____ <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Constipation/Diarrhea</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Musculoskeletal</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Exposed to infectious diseases in past 3 weeks?</u> _____ <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Diabetes</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Nosebleeds</u> <input type="checkbox"/> Y <input type="checkbox"/> N | _____ <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Emotional Disorder</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Skin Disorder</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Hepatitis in past 6 months?</u> _____ <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Epilepsy or Seizures</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Special Diet</u> <input type="checkbox"/> Y <input type="checkbox"/> N | _____ <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Eyes or Ears</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Surgeries</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Any disorder preventing strenuous activity?</u> _____ <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Fainting or Dizziness</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Wear Contact Lenses</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Any reactions to medications or drugs of any type?</u> _____ <input type="checkbox"/> Y <input type="checkbox"/> N |
| <u>Headaches</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Prescription Medication</u> <input type="checkbox"/> Y <input type="checkbox"/> N | |
| <u>Heart or Lungs</u> <input type="checkbox"/> Y <input type="checkbox"/> N | <u>Other Information</u> <input type="checkbox"/> Y <input type="checkbox"/> N | |

Food or drug allergies: _____

I am currently taking the following medications: _____

Parent/Legal Guardian Consent: The signature of a parent or legal guardian is required for a minor to attend the North Texas District Royal Rangers Camp. The parent's or legal guardian's signature below indicates permission to administer medical attention to the minor in the event of a medical emergency.

Print complete name of minor _____

Parent / Legal Guardian Signature _____ Date _____

Adult Applicant's Signature: My signature indicates my permission for emergency medical treatment should the need arise while at a North Texas District Royal Rangers camp or while traveling to or from the Campgrounds.

Adult Applicant's Signature _____ Date _____

Royal Rangers Medication Form

Camper's Name _____ Church / City _____

Please complete this form within **24 hours prior to camper's arrival at camp**. All medications must be in their original containers! Place all medication containers in a 1-gallon Ziploc Freezer bag with this completed form detailing instructions for the use of each medication your child is to receive at camp. A medical attendant will receive medications at the time of camp check-in.

NO MEDICATION MAY BE ADMINISTERED UNLESS LISTED ON THIS FORM WITH PARENT'S OR LEGAL GUARDIAN'S SIGNATURE.

All camper medications must be administered by medical attending personnel in the infirmary.

Allergies: _____

| Name of Medication | Dosage | Time To Be Given | Initials & Date/Time Given (Medic Use Only) | | | |
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Comments / Instructions _____

Medications will be given as directed on prescription containers. Explain any differences in instructions. _____

May also be given: Tylenol (Acetaminophen)? Yes or No Motrin (Ibuprophen)? Yes or No
 Aspirin? Yes or No Benadryl (Diphenhydramine)? Yes or No

My camper may be given over-the-counter, non-prescription medications or applications, not to exceed recommended dosage for cough, heartburn, stomach discomfort, burns, cuts, insect bites, rash or scrapes. Yes or No List exceptions _____

I _____, Parent or Legal Guardian of _____, (Camper's Name) authorize the North Texas District Royal Rangers Medical Staff to administer the medications listed above.

Parent / Guardian: I authorize the North Texas District Royal Rangers Camp Staff to consent to medical treatment when either I or my assignee cannot be contacted. I understand that every effort will be made to contact me before such action.

Parent / Guardian Signature _____ Date _____