Royal Rangers Medical Release Form

Royal Rangers Medical History/ Release Form - All information on this form is private & 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			Exposedtoinfections:		
Ear Problem			Skin Infection			Disease past 3weeks		
Lung Problem			Hearing Difficulty			Hepatitis past 6mths		
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:_____

Pursuant to Section 117.05(13)(a, Florida Statutes, the following notarial certificate is sufficient for an oath or affirmation:
STATE OF FLORIDA **COUNTY OF** _____

Sworn to (or affirmed) and subscribed before me by means of __ physical presence or__ on line notarization, this___ day of_____ by _____

Personally Known_____ or Produced Identification_____
Type of Identification Produced_____

Signature of Notary

Notary Stamp/Seal