

MEDICAL RECORD  
SOUTH TEXAS DISTRICT ROYAL RANGERS

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
One Child per Form Only Please.

Church Name \_\_\_\_\_ Outpost Number \_\_\_\_\_

Health History To be completed by the parent or guardian. Answer "Yes" or "No" to the following and Briefly explain all Yes answers under "Remarks".

Sinus Condition		Shortness of breath		Exposed to Infectious Disease past three weeks	
Ear Problem		Skin Infection		Exposed to Infectious Hepatitis past six months	
Lung Problem		Hearing Difficulty		Any disorder preventing Strenuous Activities	
High Blood Pressure		Bad Eyesight		Do you wear Contacts?	
Allergy-Asthma		Fainting or Dizzy Spells		Taking Prescription Medicine?	
Any Medical care within the last year?		Any Surgery within the last year?		Any Reactions to Drugs or Medicines of Any type?	

Give latest date of Inoculation or Vaccination Against the following:

Tetanus	Small Pox	Measles	Typhoid	Diphtheria	Polio

REMARKS AND MEDICAL FACTS WE SHOULD KNOW IN CASE OF EMERGENCY:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Use back of form if more space is needed.

NOTIFY IN CASE OF EMERGENCY:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone 1-A/C (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Phone 2- A/C (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

I Authorize the Providing of Medical Services in the case of an Accident, Injury, or Sickness.

\_\_\_\_\_  
Signed Parent or Guardian

\_\_\_\_\_  
Printed Parent or Guardian

\_\_\_\_\_  
Date