



## MEDICAL RECORD FORM NATIONAL ROYAL RANGER TRAINING TRAILS

### Part 1: HEALTH HISTORY

A physical examination (minimum of **SPORTS EXAM**), signed by a medical practitioner, is strongly recommended for enrollment in a National Training Trails. We recommend that this entire form be completed and mailed in with the application. However, persons arriving at camp without a medical record form, signed by a health practitioner, will be required to sign an **ASSUMPTION OF RISK FORM** at the camp. The National Royal Rangers Ministries office has the prerogative to accept or reject any person based upon his/her medical health.

HEALTH HISTORY	To be completed by the applicant and/or the physician. Answer YES or NO to the following and briefly explain all yes answers under "REMARKS."		
Sinus Condition		Shortness of Breath	Exposed to Infections
Ear Problem		Skin Infection	A) Disease Past Three Weeks
Lung Problem		Hearing Difficulty	B) Hepatitis Past Six Months
High Blood Pressure		Bad Eyesight	Any disorder Preventing Strenuous Activities
Allergy - Asthma		Do you wear contacts	Taking Prescription Medicine
Fainting or Dizzy Spells		Any Medical Care	Any Reaction to Drugs or Medication of Any Type
		Within the Past Year	
		Any Surgery Within Past Year	

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

Give Latest Date of Inoculation or Vaccination Against the Following	Tetanus	Small Pox	Measles	Typhoid	Diphtheria	Polio
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I know of no physical reason that would restrict me from participation in camp activities.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Part 2: PHYSICAL EXAMINATION

Print Applicant's Name:		Examination Date	Birth Date	Height	Weight	Occupation
BRIEFLY INDICATE CONDITION	HEART	LUNGS	THROAT		EARS	
	EYES	SKIN	HERNIA		BLOOD PRESSURE	

#### Physician Please Note:

**Trainees enrolled in outdoor activities are exposed to strenuous physical activity. Therefore, the applicant must be physically sound and strong enough to engage in such activity. In your opinion, is the applicant capable of strenuous physical activity?**

**YES \_\_\_\_\_ NO \_\_\_\_\_**

#### REMARKS:

Physician's Name	Physician's Signature
Physician's Address	Physician's Business Phone Number with Area Code