



Northern New England District Royal Rangers Emergency Medical Form



winter field day 2010 (Feb 19th-20th)

Personal Information

Name: _____ DOB: _____

Address: _____ City: _____ State: _____

Both Parents' Names: _____

Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____

Doctor's Name: _____ Doctor's Phone: _____

Health Insurance Coverage: _____

Outpost: _____ Senior Commander: _____

Health History

Check off all that apply and provide details.

Medical Conditions:

Past Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Severe Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia (Rupture)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reaction to Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Subject to:

Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reaction to Sugar	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Easily Upset	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reaction to Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reaction to Sulfa	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Poison Oak, Ivy, or Sumac	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Under Medical Care for:

Reaction to bee stings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Significant Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical restriction on activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other (List) _____		

Medications: (List All)

Permission for Emergency Medical Treatment

In the event this individual becomes ill or sustains injury while in the care of, or under the supervision of activity leaders, they are given permission to administer first aid for relief. If it is not practical to return the individual to the parents, or to receive instruction regarding care, consent is hereby given to admit this individual to any hospital. Consent is also given to any licensed nurse, physician, and/or surgeon called, or to whom this individual is taken for treatment by them to administer such treatment, drugs, and medicines, and to perform such surgical procedures as the medical professional shall think the existing emergency requires for relief of pain and to preserve the individual's life and/or health. Authorization is also given for such other measures as may be required. I hereby agree to reimburse the activity leader or leaders for any expense incurred in the care of this individual, should any type of medical treatment become necessary, to include, but not be limited to, fees for hospitals, ambulances, doctors, nurses, examinations, medically necessary tests, interpretations of tests, medical supplies, etc.

Printed Name

Signed Name

Date