

Medical Information & Authorization Form

Confidential – this document to be destroyed after the event.

Event Name: _____ Event Date(s): _____

Event Location: _____

Boy/Leader Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Father's Name:* _____ Father's Phone:* _____

Mother's Name:* _____ Mother's Phone:* _____

Family Doctor: _____ Doctor's Phone: _____

Medical Insurance Company: _____ Policy Number: _____

Medical Insurance Phone Number: _____

ADDITIONAL EMERGENCY CONTACTS (other than parents listed above):

Name: _____ Phone: _____

Name: _____ Phone: _____

MEDICAL QUESTIONNAIRE

Please answer each of the following questions by circling your response, providing details on the next page.

- 1. Are you/your son being treated for any injury or illness?..... YES NO
- 2. Are you/your son taking any medication? If so, What? & When? YES NO
- 3. Do you/your son have asthma? YES NO
- 4. Are you/your son allergic to any form of medication?..... YES NO
- 5. Do you/your son have hay fever?..... YES NO
- 6. Do you/your son have any known allergies?..... YES NO
- 7. Have you/your son had tonsils removed? YES NO
- 8. Have you/your son had appendix removed?..... YES NO
- 9. Have you/your son had any other surgical operations?..... YES NO
- 10. Does your family have any history of any disease? YES NO
- 11. Do you/your son require a special diet?..... YES NO
- 12. Do you/your son have any chronic medical conditions?..... YES NO
- 13. Have you/your son had any "childhood diseases"? (i.e. measles, chicken pox, etc.) YES NO
- 14. Do you/your son sleepwalk?..... YES NO
- 15. Are you/your son hyperactive? (If so, is he on medication?)..... YES NO
- 16. Are there any medical considerations not mentioned? YES NO
- 17. What is the date of your son's last physical exam? YES NO
- 18. What is the date of your son's last tetanus shot? YES NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN.

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN BY THIS PARTICIPANT.

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>WHAT TIME(S)?</u>	<u>REASON FOR MED</u>

AUTHORIZATIONS

FOR BOY PATICIPANTS: My son has permission to participate in the above referenced event under the supervision of the adult leaders approved by our church or those approved for leadership by the Southern Missouri District. I understand that I will be contacted as soon as possible in the event of an emergency (accident, injury, or illness). I authorize the leader in charge (or designate) to give consent for treatment of my son by qualified medical personnel in the event of an emergency. I also understand that the leader in charge of any activity has the responsibility and right to restrict any party from any activity which he feels is beyond the physical capabilities of that party.

FOR ALL PARTICIPANTS: I understand that my personal medical insurance will be the primary insurance to be billed in the event of any medical treatment or evaluation and that my church will be billed as the secondary insurance policy with the Southern Missouri District being the third insurance carrier. I acknowledge the risks inherent to events such as this and agree to hold harmless the Southern Missouri District, the national Royal Rangers organization, any authorized Royal Ranger leader, or any medical personnel for any accident, injury, or illness when reasonable precautions have been taken for my son's safety.

Signature of Adult Participant or Parent/Legal Guardian

Date

Printed Name

**Content identified with an asterisk is needed for boys only, not adults.*