Division: ____________________ Brigade: ____________________ Outpost #: ______

EMERGENCY MEDICAL INFORMATION

Duplicate one for each boy

Name ____________________ Birth Date ____________________ Age __________

Address ____________________

City ____________________ State ________________Zip Code ______________

Father/Guardian ____________________ ( ) ____________________ ( ) ____________________
Daytime phone number Evening phone number

Mother/Guardian ____________________ ( ) ____________________ ( ) ____________________
Daytime phone number Evening phone number

Physician ____________________ ( ) ____________________
Phone number

Family medical insurance information:

____
Name of Insurance Company

____
Mailing Address

____________________ ____________________ ____________________
City State Zip Code

Employer with which insurance coverage is provided: ____________________

Employer's group medical insurance account number: ____________________

CONFIDENTIAL HEALTH HISTORY

Does he have/Has he had:	YES	NO		YES	NO
Appendicitis			Heart ailments		
Asthma			Scarlet fever		
Hay fever			Hernia		
Rheumatic fever			Poliomyelitis		
Diabetes			Epilepsy		
Fainting spells			Contagious diseases		
Other					

Significant injury or operations? ____________________

Is he taking any medication? ____________________

Are his activities restricted for any reason? ____________________

Is he allergic to penicillin or other medication? ____________________

Please EXPLAIN FULLY any YES answers to this list of conditions: ____________________

____

____

Date of last tetanus shot: ____________________

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event my son becomes ill or sustains injury while in the care of or under the supervision of the Royal Rangers Outpost, or any of its officers or leaders, they are given permission to administer First Aid for his relief. Consent is also given to admit him to any hospital and for all medical, surgical, diagnostic and hospital procedures or treatment as may be performed or prescribed, including the administration of such drugs or medication, by a physician for him when such treatment is deemed immediately necessary or advisable to safeguard my child's health and it is not advisable or practical to return him to us or to receive our instruction for his care. I waive my right to informed consent for said treatment.

____________________ ____________________
Date Signature of parent or custodial guardian