

Individual Medical Form

Name _____ Notify in an emergency :

Address _____ Name _____

City _____ State _____ Address _____

Phone () _____ Zip _____ City _____ State _____ Zip _____

Date of birth _____ Ranger Outpost # _____ Emergency Phone () _____

Church _____ Section # _____ Relationship _____

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	
Ear Problem		Skin Infection	
Lung Problem		Hearing Difficulty	
High Blood Pressure		Bad Eyesight	
Allergy - Asthma		Do you wear contacts	
Fainting or Dizzy Spells		Any Medical Care	
Allergy - Horse Serum		Within the Past Year	
		Any Surgery Within Past Year	
		Exposed to Infections	
		A) Disease Past Three Weeks	
		B) Hepatitis Past Six Months	
		Any disorder preventing strenuous activities	
		Taking Prescription Medicine	
		Any Reaction to Drugs or Medication of Any Type	

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

Date of last Tetanus booster _____

In the event hospitalization is needed, please fill in :

Name of insured _____

Medical / Hospital insurance company : _____

Policy or certificate number : _____

Employer _____

In case of an emergency, I hear by give permission to the physician at hand to render treatment. Should the physician deem it necessary, I authorize hospitalization, anesthesia, surgery, or injection of medication.

Signature (Parent, if minor) _____ Date: _____

Signature of Notary _____ Date _____ Seal :