

# Christ the King Royal Rangers Medical Form

*All information on this form is Private & shall remain Confidential*

Full Name \_\_\_\_\_ Birthday \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Father/Guardian \_\_\_\_\_

City, St, Zip \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Phone Numbers ( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_

1) Emergency Contact \_\_\_\_\_  
 Relation \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Mother/Guardian \_\_\_\_\_

2) Emergency Contact \_\_\_\_\_  
 Relation \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Email Address \_\_\_\_\_

**HEALTH HISTORY** Check either Yes or No. If Yes is checked please explain under "Remarks and Medical Facts".

Sinus Condition <input type="radio"/> YES <input type="radio"/> NO	Shortness of Breath <input type="radio"/> YES <input type="radio"/> NO	Exposed to Infections: Disease past 3 weeks <input type="radio"/> YES <input type="radio"/> NO
Ear Problem <input type="radio"/> YES <input type="radio"/> NO	Skin Infection <input type="radio"/> YES <input type="radio"/> NO	Hepatitis past 6 months <input type="radio"/> YES <input type="radio"/> NO
Lung Problem <input type="radio"/> YES <input type="radio"/> NO	Hearing Difficulty <input type="radio"/> YES <input type="radio"/> NO	Any disorder preventing strenuous activity? <input type="radio"/> YES <input type="radio"/> NO
Heart Trouble <input type="radio"/> YES <input type="radio"/> NO	Bad Eyesight <input type="radio"/> YES <input type="radio"/> NO	Taking prescription medicine? <input type="radio"/> YES <input type="radio"/> NO
High Blood Pressure <input type="radio"/> YES <input type="radio"/> NO	Wear Eye Glasses <input type="radio"/> YES <input type="radio"/> NO	Any Reaction to drugs or medicine of any type? <input type="radio"/> YES <input type="radio"/> NO
Allergy-Asthma <input type="radio"/> YES <input type="radio"/> NO	Wear Contact Lenses <input type="radio"/> YES <input type="radio"/> NO	Get nervous or upset easily? Homesick? <input type="radio"/> YES <input type="radio"/> NO
Fainting or Dizzy Spells <input type="radio"/> YES <input type="radio"/> NO	Any Medical Care within Past Year? <input type="radio"/> YES <input type="radio"/> NO	Sleep Walker? <input type="radio"/> YES <input type="radio"/> NO
Diabetes <input type="radio"/> YES <input type="radio"/> NO	Any Surgeries within Past Year? <input type="radio"/> YES <input type="radio"/> NO	
Appendix Removed <input type="radio"/> YES <input type="radio"/> NO	Special Diet Required? <input type="radio"/> YES <input type="radio"/> NO	
Dental Appliances <input type="radio"/> YES <input type="radio"/> NO		

Drug Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Plant, Insect or Animal Allergies: \_\_\_\_\_

Remarks and Medical Facts: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Food Allergies or Special Diet: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Last Tetanus Shot \_\_\_\_/\_\_\_\_/\_\_\_\_

Swimming Level (Please Circle):  
Non Swimmer, Beginner, Intermediate, Advanced

**Doctor and Insurance Info**

\_\_\_\_\_( ) \_\_\_\_\_ - \_\_\_\_\_  
Doctor's Name & Phone

\_\_\_\_\_( ) \_\_\_\_\_ - \_\_\_\_\_  
Insurance Company & Phone

\_\_\_\_\_  
Policy ID# and Group Number

\_\_\_\_\_  
Subscriber's Name & Relationship