

# First Assembly Of God Royal Rangers Medical Form

**Instructions: Please complete a copy of this form for each individual registering.**

Full Name \_\_\_\_\_ Father/Guardian \_\_\_\_\_  
 Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_ Cell Phone ( ) \_\_\_\_-\_\_\_\_ Work Phone ( ) \_\_\_\_-\_\_\_\_  
 Address \_\_\_\_\_ Mother/Guardian \_\_\_\_\_  
 City,St,Zip \_\_\_\_\_ Cell Phone ( ) \_\_\_\_-\_\_\_\_ Work Phone ( ) \_\_\_\_-\_\_\_\_  
 Phone Numbers( ) \_\_\_\_-\_\_\_\_ ( ) \_\_\_\_-\_\_\_\_  
 1) Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone ( ) \_\_\_\_-\_\_\_\_  
 2) Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone ( ) \_\_\_\_-\_\_\_\_

**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 Contact Lenses <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	Any Medical Care within Past Year? <input type="radio"/> YES <input type="radio"/> NO	Nervous or upset easily <input type="radio"/> YES <input type="radio"/> NO
Fainting or Dizzy Spells <input type="radio"/> YES <input type="radio"/> NO	Any Surgeries 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	Special Diet Required? <input type="radio"/> YES <input type="radio"/> NO	
Appendix Removed <input type="radio"/> YES <input type="radio"/> NO		

Drug Allergies \_\_\_\_\_ Last Tetanus Shot \_\_\_\_/\_\_\_\_/\_\_\_\_

Currently taking the following medications \_\_\_\_\_ Swimming Level (Please Circle):  
 Non Swimmer, Beginner, Intermediate, Advanced

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

Remarks and Medical Facts: \_\_\_\_\_ Doctor and Insurance Info  
 \_\_\_\_\_ ( ) \_\_\_\_-\_\_\_\_  
 \_\_\_\_\_ Doctor's Name & Phone  
 \_\_\_\_\_ ( ) \_\_\_\_-\_\_\_\_  
 \_\_\_\_\_ Insurance Company & Phone  
 \_\_\_\_\_ Policy and/or Group Number  
 \_\_\_\_\_ Subscriber's Name & Relationship

Food Allergies or Special Diet? \_\_\_\_\_

Additional Remarks: \_\_\_\_\_