

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: _____