# ROYAL RANGERS PERSONAL MEDICAL RECORD

CAMPER ID: *(for camp use only)*

A Personal Medical Record (PMR) form must be submitted for every individual (adult or minor) attending Royal Rangers events. Forms provided for minors must include the signature of a parent or guardian. Event participation is conditioned upon the participant's (and parent's or guardian's) acceptance of terms as stated below concerning the administration of emergency medical treatment. This form is intended to supplement event registration and parental consent-to-participate forms.

PARTICIPANT'S NAME: _____ DOB: _____ Age: ____ District: _____ Outpost: ____

MEDICAL INSURANCE: Insur. Company Name: _____ Phone: _____ Policy #: _____

*Attach a photocopy of both sides of your insurance card. If you do not have medical insurance, enter "none" above.*

HEALTH HISTORY: Do you currently have, or have you ever been treated for any of the following?

| Y | N | Condition |
|---|---|---|
| | | *Abdominal/digestive problems* |
| | | *Asthma* |
| | | *Behavioral/neurological disorders* |
| | | *Bleeding disorders* |
| | | *Ear/sinus problems* |
| | | *Excessive fatigue or breathing problems* |
| | | *Fainting spells* |
| | | *Kidney disease* |
| | | *Thyroid disease* |

| Y | N | Condition |
|---|---|---|
| | | *Heart disease, heart attack, heart murmur* |
| | | *Hypertension, high blood pressure* |
| | | *Stroke* |
| | | *Lung/respiratory disease* |
| | | *Muscular/skeletal condition* |
| | | *Menstrual problems (women only)* |
| | | *Sickly cell disease* |
| | | *Seizures* |
| | | *Sleep disorders* |

Are you allergic to, or have you experienced an adverse reaction to, any of the following?

| Y | N | Condition |
|---|---|---|
| | | *Medication* |
| | | *Food* |

| Y | N | Condition |
|---|---|---|
| | | *Plants* |
| | | *Insect bites or stings* |

If yes to any, please explain: _____

_____

IMMUNIZATIONS: The following immunizations are recommended for participation in Royal Rangers events. Indicate below if you have received the immunization, the date received, whether or not you've had the disease, and if so, the date.

| Immunized? | | | | Had disease? | | |
|---|---|---|---|---|---|---|
| Y | N | Immunization | Date Received | Y | N | Date(s) you had the disease |
| | | *Tetanus* | | | | |
| | | *Pertussis* | | | | |
| | | *Diphtheria* | | | | |
| | | *Measles* | | | | |
| | | *Mumps* | | | | |
| | | *Rubella* | | | | |
| | | *Polio* | | | | |
| | | *Chicken Pox* | | | | |
| | | *Hepatitis A* | | | | |
| | | *Hepatitis B* | | | | |
| | | *Meningitis* | | | | |
| | | *Influenza* | | | | |

MEDICATIONS: Please indicate below all medications currently being used, including items for occasional or emergency use. Attached additional forms is additional space is needed.

| Medication | Strength | Frequency | Aprox. Date Started | Needed For |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please provide additional information concerning current health or medical conditions not referenced elsewhere: _____

_____

_____

AUTHORIZATION FOR TREATMENT: I hereby affirm the above information to be true and complete to the best of my knowledge, and consent to the administration of emergency medical care at the discretion of the adult leaders attending. Administration of the medications listed above by designated adult personnel is also hereby authorized.

_____ _____ _____

*Signature of Participant* *Date* *Please print name of signer*

*(or Parent/Guardian if participant is less than 18 years of age)*