Individual Medical Form

Health History and Medical Permission Form

One form per person (Must have a copy of this for every boy and man when you register at event/camp for **Hope Evangelical Community Church.**)

Please print

Today's Date _____

Name _____ Name _____

Address _____ Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Phone ( ) _____ Emergency Phone ( ) _____

Date of Birth _____Relationship _____

Grade _____Parent Email Address _____

Ranger Outpost # _____Church Name _____City _____State___

NOTIFY IN AN EMERGENCY:

Have you ever been treated for any of the following? If yes, check the box.

- ❑ Heart disease
- ❑ Seizures
- ❑ High blood pressure
- ❑ Asthma
- ❑ Bronchitis
- ❑ Diabetes

Please provide additional information about any items (checked Yes) to left.

_____

_____

_____

_____

_____

Date of last Tetanus booster _____
(month and year)

Please identify any allergies, physical impairments or limitations: _____

_____

_____

Please list any medications being taken:

_____

_____

Do you wear: (If yes, check the box.)

- ❑ Contacts
- ❑ Glasses
- ❑ Dental appliance

IN THE EVENT HOSPITALIZATION IS NEEDED, PLEASE FILL IN BELOW

Name of Insured: _____
(POLICY HOLDER)

MEDICAL / HOSPITAL INSURANCE COMPANY: _____

POLICY OR CERTIFICATE NUMBER: _____

EMPLOYER: _____ EMPLOYER'S GROUP: _____

NUMBER: _____ SUBSCRIBER'S DATE OF BIRTH: _____

In case of emergency, I herby give permission to the physician to render treatment. Should the physician deem necessary, I authorize hospitalization, anesthesia, surgery or injection of medication.

_____ _____

Signature (Parent, if minor) *Date*

Name of person to contact (Commander or Adult) on premises for information:

_____