

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

NOTIFY IN AN EMERGENCY:

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 _____

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 hereby 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:
