

Medical Record

Applicant's Full Name _____ Outpost # _____

Health History

A complete Health History must be completed by the applicant's parent / guardian to attend Academy.

- | | | | | | |
|--------------------------|--|--------------------------------|--|--|--|
| Sinus condition | <input type="radio"/> YES <input type="radio"/> NO | Shortness of breath | <input type="radio"/> YES <input type="radio"/> NO | Exposed to infectious: | |
| Ear problem | <input type="radio"/> YES <input type="radio"/> NO | Skin infection | <input type="radio"/> YES <input type="radio"/> NO | Disease past 3 weeks | <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 | Hepatitis past 6 months | <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 | Any disorder preventing strenuous activity? | <input type="radio"/> YES <input type="radio"/> NO |
| High blood pressure | <input type="radio"/> YES <input type="radio"/> NO | Wear eyeglasses? | <input type="radio"/> YES <input type="radio"/> NO | Taking prescription medicine? | <input type="radio"/> YES <input type="radio"/> NO |
| Allergy-Asthma | <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 |
| Fainting or dizzy spells | <input type="radio"/> YES <input type="radio"/> NO | Any medical care in past year? | <input type="radio"/> YES <input type="radio"/> NO | Home Sickness | <input type="radio"/> YES <input type="radio"/> NO |
| Diabetes | <input type="radio"/> YES <input type="radio"/> NO | Any surgery within past year? | <input type="radio"/> YES <input type="radio"/> NO | | |
| Appendix removed | <input type="radio"/> YES <input type="radio"/> NO | Special diet required? | <input type="radio"/> YES <input type="radio"/> NO | | |
| Dental Appliances | <input type="radio"/> YES <input type="radio"/> NO | | | | |

Food, Drug and/or other Allergies: _____

I am currently taking the following medications: _____

Please include written instructions for all medications.

Remarks and Medical Facts We Should Know: (Add Sheet if Needed)

Give latest date of inoculation or vaccination against the following:

- | | | | |
|------------|-----------------|---------|-----------------|
| Tetanus | ___ / ___ / ___ | Hep B | ___ / ___ / ___ |
| Measles | ___ / ___ / ___ | Typhoid | ___ / ___ / ___ |
| Diphtheria | ___ / ___ / ___ | Polio | ___ / ___ / ___ |
| Flu Shot | ___ / ___ / ___ | | |

Physical Examination (Optional)

Note to Health Practitioner: Applicants attending Advancement Academy are exposed to hot, strenuous activity. Therefore, the applicant must be physically sound and strong enough to engage in such activity. Your signature below indicates the applicant is able to attend this event.

EXAMINATION DATE ___ / ___ / ___	BIRTH DATE ___ / ___ / ___	HEIGHT ' "	WEIGHT lbs
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HEALTH PRACTITIONER'S NAME (Please Print) _____

HEALTH PRACTITIONER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

(_____) _____

HEALTH PRACTITIONER'S AREA CODE AND PHONE NUMBER _____

In Case of Emergency Please Notify:

NAME _____	RELATIONSHIP _____
ADDRESS _____	CITY _____ STATE _____ ZIP _____
(_____) _____	(_____) _____
DAY PHONE _____	EXT. _____ EVENING PHONE _____
2nd EMERGENCY CONTACT _____	PHONE NUMBER _____

Health Insurance Company Info:

HEALTH INSURANCE COMPANY'S NAME _____

POLICY NUMBER _____ CARD HOLDER'S NAME _____

CERTIFICATE NUMBER _____

_____ / _____ / _____ (_____) _____

EFFECTIVE DATE OF COVERAGE HEALTH INSURANCE COMPANY'S PHONE

Parent/Legal Guardian Consent: The signature of a parent or legal guardian is required for a minor to attend the 2006 NJ Royal Rangers Advancement Academy at Camp Roosevelt in Aldine, NJ - August 13-19, 2006. The parent's or legal guardian's signature below indicates: Permission to administer medical attention to the minor in the event of a medical emergency and verifies the applicant has completed at least the Fourth Grade.

X

 PARENT'S/GUARDIAN'S SIGNATURE DATE

Senior Commander: While Advancements and Merit Awards are important, "Reaching, Teaching and Keeping boys for CHRIST" is the Academy's main goal. Please assist your boy(s) in checking and trying to complete any prerequisites before the Academy. This will help us insure that the boy is "READY" for the Academy. Thank you for your time, cooperation and information. Address is needed for sending back paperwork, which will be mailed out by Oct 1st.

X

 SENIOR COMMANDER'S NAME (Please Print) SENIOR COMMANDER'S SIGNATURE DATE

ADDRESS _____

CITY _____ STATE _____ ZIP _____

(_____) _____ PHONE NUMBER _____

_____ E-MAIL ADDRESS _____ NO EMAIL

Required Release Signatures