

# 2019 New Mexico Royal Rangers | 2019 NMRR District Ranger Camp

## Medical History & Release

Camper's Name: \_\_\_\_\_ Church: \_\_\_\_\_

| In case of emergence, please notify: | Insurance Information          |
|--------------------------------------|--------------------------------|
| Name: _____                          | Health Insurance Carrier _____ |
| Relationship to camper _____         | Phone Number _____             |
| Home Phone _____                     | Policy ID # _____              |
| Cell Phone _____                     | Group Number _____             |

I understand that my personal insurance will be the primary insurance policy to be billed in the event of any medical treatment or evaluation. Any expenses incurred that insurance policies will not pay; they will be my responsibility as the parent/guardian.

### Health History

To be completed by the applicant (if 18 years or older) or by a parent/guardian if the applicant is a minor (under age 18). Has the applicant ever experienced any of the following? Check either **Y (Yes)** or **N (No)**. If yes, please explain in the Additional Information section.

|               |               |                   |                          |
|---------------|---------------|-------------------|--------------------------|
| Height: _____ | Weight: _____ | Birth date: _____ | Tetanus Shot Date: _____ |
|---------------|---------------|-------------------|--------------------------|

|                     | Y                        | N                        |                           | Y                        | N                        |                         | Y                        | N                        |
|---------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|
| Sinus Condition     | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath       | <input type="checkbox"/> | <input type="checkbox"/> | Infectious Diseases     | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear Problem         | <input type="checkbox"/> | <input type="checkbox"/> | Skin Infection            | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis in past 6 mo  | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung Problem        | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Difficulty        | <input type="checkbox"/> | <input type="checkbox"/> | Anger / Depression      | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble       | <input type="checkbox"/> | <input type="checkbox"/> | Bad Eyesight              | <input type="checkbox"/> | <input type="checkbox"/> | Prescription Medication | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Wear Glasses              | <input type="checkbox"/> | <input type="checkbox"/> | OTC Medications         | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy/Asthma      | <input type="checkbox"/> | <input type="checkbox"/> | Wear Contacts             | <input type="checkbox"/> | <input type="checkbox"/> | Drug or Food Allergies  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Dizzy    | <input type="checkbox"/> | <input type="checkbox"/> | Medical Care in Past Year | <input type="checkbox"/> | <input type="checkbox"/> | Special Dental          | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries in Past Year    | <input type="checkbox"/> | <input type="checkbox"/> | Special Diet            | <input type="checkbox"/> | <input type="checkbox"/> |

**Current Medications:** \_\_\_\_\_

**Additional Information:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Adult Applicant Signature:** My signature indicates my permission for emergency medical treatment should the need arise while at a New Mexico Royal Rangers event or while traveling to or from the campground.

Adult Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent / Legal Guardian Consent:** The signature of a parent or legal guardian is required for a minor to attend a New Mexico Royal Rangers camp. The parent's or legal guardian's signature below indicates permission to administer medical attention to the minor when necessary.

Print Complete Name of Minor: \_\_\_\_\_

Parent / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_