

South Texas District Royal Ranges Medical Record

Name: _____ Age: _____ Date of Birth: _____
 One form per person

Church Name: _____ Outpost #: _____

GENERAL HEALTH HISTORY: To be completed by the leader. Answer "Yes" or "No" to the following and briefly explain all Yes answers under "Remarks".

| | | | | | |
|--------------------------|--|------------------------------------|--|------------------------------------------------------------|--|
| Sinus Condition | | Shortness of Breath | | Exposed to Infectious Disease within the past three weeks? | |
| Ear problem | | Skin Infection | | Exposed to Hepatitis within past six months? | |
| Lung problem | | Hearing Difficulty | | Any known Reaction to Drugs or Medications of any type? | |
| Heart Trouble | | Bad Eyesight | | Taking Prescription Medicine? | |
| High Blood Pressure | | Do you wear Contact Lenses | | Any Physical Restrictions from Normal Outdoor Activities | |
| Allergy - Asthma | | Any Medical care within past year? | | Any disorder preventing Strenuous Activity | |
| Fainting or Dizzy Spells | | Any Surgery within past year? | | | |

REMARKS AND MEDICAL FACTS WE SHOULD KNOW IN CASE OF EMERGENCY:

Use back of form if more space is needed.

| | | | | | | |
|----------------------------------------------------------------------------------|---------|-----------|---------|----------------------------|------------|-------|
| Give latest date (if known) of Inoculation or Vaccination against the following: | Tetanus | Small Pox | Measles | Typhoid | Diphtheria | Polio |
| Physician's Name and address: | | | | Area Code and Phone Number | | |
| Name, address and relationship of person to notify in case of emergency: | | | | Area Code and Phone Number | | |

Signature: _____ Date: _____