



## Medical and Media Record

This medical record *must be completed for everyone attending Knoxville Sectional Ranger Kids Day Camp Event* (man, woman & boy). It must be turned in upon arrival at Ranger Kids Day Camp Event to Registration along with permission slips and leader screening forms. If emergency service involving medical action or treatment is required I hereby consent to the rendering of emergency medical treatment deemed appropriate in the opinion of the doctor rendering such services. I also understand and consent to the use of media footage, video, audio and photos of my child at this activity for the use of Royal Rangers promotional material and relinquish rights of ownership or compensation. It is understood that acceptance of these terms are a condition of participation in this event.

Name \_\_\_\_\_ / Boy \_\_\_\_ /Adult \_\_\_\_

Parent or Adult Guardian Signature \_\_\_\_\_

Outpost # \_\_\_\_\_ Church Name \_\_\_\_\_

Answer **Yes** or **No** to the following. Explain all Yes answers under **Remarks** below.

- |                                   |                                      |
|-----------------------------------|--------------------------------------|
| 1. _____ Sinus condition          | 8. _____ Shortness of breath         |
| 2. _____ Ear problems             | 9. _____ Skin Infection              |
| 3. _____ Lung problems            | 10. _____ Hearing difficulty         |
| 4. _____ High blood pressure      | 11. _____ Bad eyesight               |
| 5. _____ Allergy or asthma        | 12. _____ Wear contact lenses        |
| 6. _____ Heart problems           | 13. _____ Any medical care this year |
| 7. _____ Fainting or dizzy spells | 14. _____ Any surgery this year      |
15. \_\_\_\_\_ Have you been exposed to any disease in the last three weeks?  
16. \_\_\_\_\_ Have you been exposed to hepatitis in past 6 months?  
17. \_\_\_\_\_ Do you have any disorder preventing strenuous activity?  
18. \_\_\_\_\_ Are you taking any prescription medication?  
19. \_\_\_\_\_ Any known reactions to drugs or medication of any type?

Latest date of inoculations or vaccinations for:

_____ Tetanus	_____ Small pox	_____ Measles
_____ Typhoid	_____ Diphtheria	_____ Polio

**REMARKS:** or other medical facts in case of emergency:

Begin with item #, then comment. Example: 11. eye glasses required.

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