

Medical History and Questionnaire

Member's Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Parent Contact (Name and phone number): _____

In the event that I may not be reached, please contact (name, relation and phone number):

1: _____

2: _____

Health Insurance Information

Name of Company: _____

Name of Subscriber: _____

Policy Number: _____ Group Number: _____

Please attach a copy of your health/dental insurance cards to this form

1. Is the member allergic to any medication (prescription or non-prescription)?

Yes _____ No _____ If yes, please list medication and reaction: _____

2. Does the member have a history of any childhood disease/illness? Yes ___ No ___

If yes, please list: _____

3. Is the member diabetic? Yes _____ No _____

If yes, please list medications and how condition is controlled: _____

4. Does the member take medications for any other condition not listed above?

Yes _____ No _____ If yes, please list medication and purpose: _____

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5. Does the member wear: contacts____ glasses____ braces/retainer____

6: Name of Physician: _____ Contact number: _____

Name of Dentist: _____ Contact number: _____

Parent Release of Medication Form

I, _____, do hereby grant permission to the Brook Park Rangerettes/Wranglers Organization to administer fever reducer/headache medication to the member, _____, in the event the need should arise.

(please mark all the apply):

Children's Tylenol

Motrin Jr.

Adult Tylenol

Adult Ibuprofen

I, _____, do NOT grant permission to the Brook Park Rangerettes/Wranglers Organization to administer fever reducer/headache medications to the member, _____, in the event the need should arise.

Parent/Guardian Signature: _____ Date: _____

I am of legal age to self administer fever reducing/headache medications.

Member Signature: _____ Date: _____

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I, _____, grant permission to The Rangerettes/Wranglers Director or head chaperone, to act as guardian for the administration of any treatment deemed necessary by the above referenced doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist. I grant permission for my child to be transferred to any hospital reasonably accessible in the event of my absence. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

I understand that The Rangerettes/Wranglers Organization will not be responsible for illness, injury or any other type of harm suffered or incurred by the member from or in conjunction with any activity The Rangerettes/Wranglers Organization is involved in.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

STATE OF OHIO)
)SS:
COUNTY OF _____)

The foregoing instrument was acknowledged before me on this ____ day of _____, 20__, by _____.

NOTARY PUBLIC