

Medical History Form

I hereby give consent for the following medical care providers to be called:

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Medical Specialist _____ Phone _____

I grant permission to _____ of the
Rangerettes /Wranglers Organization, to act as guardian/spokesman for (1) the administration of
any treatment deemed necessary by above-named doctors, or, in the event the designated
preferred practitioner is not available, by another licensed physician or dentist; (2) and the
transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medial opinions of two other licensed
physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the
performance of such surgery.

Parents Signature _____ Date _____

Parents Signature _____ Date _____

Signed this date _____ by _____

In front of me _____ a notary for the state of Ohio.

Signature of Notary

Printed signature of Notary

My commission expires on _____

Medical History

Name _____ DOB _____

Address _____

Phone _____

1. Is your child allergic to any medication (prescription or non prescription)? ___ Yes ___ No

If yes, please describe. _____

2. Does your child have any history of :

Rheumatic Fever _____ Asthma _____

Allergies (including food and insects) _____ Seizures _____

Fainting _____ High Blood Pressure _____

If yes, please describe? _____

3. Is your child a diabetic? ___ Yes ___ No If yes, please explain what type of diabetes,

how it is controlled, and type of medication _____

4. Is your child on any maintenance medication? ___ Yes ___ No If yes, please explain.

5. Blood type if known _____ Normal Blood Pressure _____

6. Please list any other conditions that we should be aware of. _____

7. Does your child wear: ___ contact lenses ___ glasses ___ braces/retainer

Parent/Guardian Name _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

IN THE EVENT THAT I CANNOT BE REACHED, PLEASE CONTACT:

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

Health Insurance

Name _____ Company _____

Policy Number _____

Group Number _____

Please attach a copy of your health & dental insurance cards with this form.

Parent Pain Reliever/Fever Reducer Release Form

I, _____, do hereby grant permission to the Brook Park Wranglers/Rangerettes to administer pain reliever/fever reducer to my child, _____, in the event the need should arise.

Grant permission to administer the following medicines to my child (mark all that applies):

Children's Tylenol

Motrin Jr.

Extra Strength Tylenol (Rangerettes Only)

I, _____, do NOT grant permission to the Brook Park Wranglers/Rangerettes to administer pain reliever/fever reducer to my child, _____, in the event the need should arise.

Parent/Guardian signature _____ Date _____