

**THIS FORM FOR ADULT LEADERS AGE 18 AND UP ONLY**  
**SOUTH CAROLINA CONFERENCE ROYAL RANGERS**  
**EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION**  
**FOR ADULT LEADERS**

(PLEASE TYPE OR PRINT. ALL INFORMATION IS REQUIRED. INCLUDE AREA CODE FOR ALL PHONE NUMBERS.)

Name: _____		Date of birth: _____	
Address: _____	City: _____	State: _____	Zip: _____
Home Phone: (    )    -	Work Phone: (    )    -	Cell Phone: (    )    -	
Family Doctor (FULL NAME): _____		Dr's Phone:(    )    -	
Spouse or Nearest Relative: _____		Phone:(    )    -	
OR Neighbor: _____		Phone:(    )    -	

**CERTIFICATIONS – indicate expiration date. Leave blank if not current or not applicable.**

Lifeguard Certification: _____	CPR/AED Certification: _____	1 <sup>st</sup> Aid Certification: _____	None: <input type="checkbox"/>
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**Medical History**

Sinus Condition <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart trouble <input type="checkbox"/> YES <input type="checkbox"/> NO	Reaction to stinging or biting insects <input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of Breath <input type="checkbox"/> YES <input type="checkbox"/> NO	High blood pressure <input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting or dizzy spells <input type="checkbox"/> YES <input type="checkbox"/> NO
Ear Problem <input type="checkbox"/> YES <input type="checkbox"/> NO	Blood disorder <input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO
Skin infection, rash, eczema <input type="checkbox"/> YES <input type="checkbox"/> NO	Bad eyesight <input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO
Had heat illness or exhaustion <input type="checkbox"/> YES <input type="checkbox"/> NO	Wear contact lenses <input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease <input type="checkbox"/> YES <input type="checkbox"/> NO
Lung problem <input type="checkbox"/> YES <input type="checkbox"/> NO	Pollen/environmental Allergy/Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO	Appendix removed <input type="checkbox"/> YES <input type="checkbox"/> NO
Hearing problem <input type="checkbox"/> YES <input type="checkbox"/> NO	Allergy, Food <input type="checkbox"/> YES <input type="checkbox"/> NO	Special Diet required <input type="checkbox"/> YES <input type="checkbox"/> NO

  

Taking prescription medicines, over-the-counter (OTC) Medicines or inhalers YES <input type="checkbox"/> NO <input type="checkbox"/> Been restricted from any strenuous activity, exercise or sports YES <input type="checkbox"/> NO <input type="checkbox"/> Have you ever had surgery YES <input type="checkbox"/> NO <input type="checkbox"/>	Any reaction to drugs or medicines of any type YES <input type="checkbox"/> NO <input type="checkbox"/> Diagnosed and/or treated for any infectious disease in the past year YES <input type="checkbox"/> NO <input type="checkbox"/> Diagnosed with Hepatitis YES <input type="checkbox"/> NO <input type="checkbox"/> Date of last Tetanus shot _____
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Please explain any "YES" you may have answered on the above section in the space provided below. For all current prescription and OTC medications include name of medication, doses and special instructions. Please be specific regarding strength, interval between doses, time of administration and special instructions/precautions. Use back of form as needed.

**Information, Directions and other information**

Signature: \_\_\_\_\_ Date\*: \_\_\_\_\_

Please sign form in the presence of a Notary Public

\*This form is valid for one year from date of signature.

Notary Public Signature: \_\_\_\_\_

My commission expires: \_\_\_\_\_

The seal is **required** by the SC Conference Royal Rangers

**(Seal)**