

EMERGENCY MEDICAL FORM / PERMISSION SLIP / BOY

Shooting Sport & Camping Weekend

Name: _____ Birth Date: ____/____/____ Age: _____ Grade: _____ Address: _____ City/Town: _____ State: _____ ZIP _____ Both Parents Names: _____ Doctor: _____ Phone: _____ Health Insurance Company/Policy #: _____

Outpost#: _____

HEALTH HISTORY

HAS HE HAD THE FOLLOWING:
An attack of appendicitis Yes No
Severe Allergies Yes No
Asthma or hay fever Yes No
Diabetes and/or Insulin Yes No
Hernia (rupture) Yes No
Rheumatic fever Yes No
Scarlet fever Yes No

IS HE SUBJECT TO:
Sinus trouble Yes No
Fainting spells Yes No
Ear trouble Yes No
Convulsions Yes No
Sugar reaction Yes No
Nervousness or easily upset Yes No
Reaction to penicillin Yes No
Poison ivy, oak or sumac Yes No

IS HE/SHE UNDER MEDICAL CARE WITH MEDICATION
Reaction to bee stings Yes No
Significant disease, injury/operation: Yes No
Is his activity restricted medically Yes No

Other Necessary Medical Information

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event: _____ becomes ill or sustains injury while in the care of or under the supervision of activity leaders, they are given permission to administer first aid for his relief. Consent is hereby given to admit him to any hospital; consent is also given to any licensed physician and or surgeon called, or to whom our son is taken for treatment by them to administer such treatment, drugs and medicines, and to perform such medical/surgical procedures as he shall deem the existing emergency requires for relief of pain and to preserve his life and health. I hereby agree to reimburse any and all persons and/or facilities for any expenses incurred in the care of my son, should medical treatment be necessary.

I also give my son permission to go to the **NNED DISTRICT Shooting Sport & Spirit Challenge Weekend in Holderness, New Hampshire on June 1 through June 3, 2012**

Date: _____ Signature: _____
Parent/Guardian

Phone number where you may be reached in case of emergency during the above dates:

(_____) _____

EMERGENCY MEDICAL FORM / ADULT

Shooting Sport & Camping Weekend

Name: _____

Birth Date: ____/____/____ Age: _____

Address: _____

City/Town: _____ State: _____ ZIP _____

Name of closest relative: _____ Relationship _____

Doctor: _____ Phone: _____

Health Insurance Company/Policy #: _____

Outpost#: _____

HEALTH HISTORY

HAS HE/SHE HAD THE FOLLOWING:

An attack of appendicitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Severe Allergies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Asthma or hay fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes and/or Insulin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hernia (rupture)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Rheumatic fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Scarlet fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

IS HE/SHE SUBJECT TO:

Sinus trouble	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Fainting spells	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Ear trouble	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Convulsions	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Sugar reaction	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Nervousness or easily upset	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Reaction to penicillin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Poison ivy, oak or sumac	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

IS HE/SHE UNDER MEDICAL CARE WITH MEDICATION

Reaction to bee stings	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Significant disease, injury/operation:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is his/her activity restricted medically	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Other Necessary Medical Information

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event: _____ becomes ill or sustains injury while in the care of or under the supervision of activity leaders, they are given permission to administer first aid for his/her relief. Consent is hereby given to admit him/her to any hospital; consent is also given to any licensed physician and or surgeon called, or to whom he/she is taken for treatment by them, to administer such treatment, drugs and medicines, and to perform such medical/surgical procedures as they shall deem the existing emergency requires for relief of pain and to preserve his/her life and health. I hereby agree to reimburse any and all persons and/or facilities for any expenses incurred, should medical treatment be necessary.

Date: _____ Signature: _____

Phone number where closest relative may be reached in case of emergency:

(_____) _____