EMERGENCY MEDICAL FORM / PERMISSION SLIP / BOY

Shooting Sport & Camping Weekend

Name:_____ **Outpost#:____**

Birth Date:_____/_____/_____Age:_____ Grade:_____

Address:_____

City/Town:_____State:_____ZIP_____

Both Parents Names:_____ _____

Doctor:_____Phone:_____

Health Insurance Company/Policy #:_____

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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

_____

_____

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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:_____ **Outpost#:____**

Birth Date:_____/_____/_____Age:_____

Address:_____

City/Town:_____State:_____ZIP_____

Name of closest relative:_____Relationship_____

Doctor:_____Phone:_____

Health Insurance Company/Policy #:_____

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HEALTH HISTORY

HAS HE/SHE 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/SHE 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/her activity restricted medically	Yes ☐	No ☐

Other Necessary Medical Information

_____

_____

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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:

(_____)_____