2019 Texas Louisiana Hispanic Royal Rangers | 2019 TLHD Pow-wow
Medical History & Release

Camper's Name: ______________________ Church: ______________________

In case of emergence, please notify:	**Insurance Information**
Name:	Health Insurance Carrier
Relationship to camper	Phone Number
Home Phone	Policy ID #
Cell Phone	Group Number

I understand that my personal insurance will be the primary insurance policy to be billed in the event of any medical treatment or evaluation. Any expenses incurred that insurance policies will not pay; they will be my responsibility as the parent/guardian.

Health History

To be completed by the applicant (if 18 years or older) or by a parent/guardian if the applicant is a minor (under age 18). Has the applicant ever experienced any of the following? Check either **Y (Yes)** or **N (No).** If yes, please explain in the Additional Information section.

Height: __________ Weight: __________ Birth date: __________ Tetanus Shot Date: __________

	Y	N		Y	N		Y	N
Sinus Condition			Shortness of Breath			Infectious Diseases		
Ear Problem			Skin Infection			Hepatitis in past 6 mo		
Lung Problem			Hearing Difficulty			Anger / Depression		
Heart Trouble			Bad Eyesight			Prescription Medication		
High Blood Pressure			Wear Glasses			OTC Medications		
Allergy/Asthma			Wear Contacts			Drug or Food Allergies		
Fainting / Dizzy			Medical Care in Past Year			Special Dental		
Diabetes			Surgeries in Past Year			Special Diet		

Current Medications: ______________________

Additional Information: ______________________

Adult Applicant Signature: My signature indicates my permission for emergency medical treatment should the need arise while at a Texas Louisiana Hispanic Royal Rangers event or while traveling to or from the campground.

Adult Applicant's Signature: ______________________ Date: ______________

Parent / Legal Guardian Consent: The signature of a parent or legal guardian is required for a minor to attend a Texas Louisiana Hispanic Royal Rangers camp. The parent's or legal guardian's signature below indicates permission to administer medical attention to the minor when necessary.

Print Complete Name of Minor: ______________________

Parent / Legal Guardian Signature: ______________________ Date: ______________