California Rangers
Incorporated 1948

Medical Examination Report Form

Name: _____ DOB: _____ Troop: _____ Date: _____

To be filled out by the applicant's physician:

	Yes	No
Allergies:	☐	☐
Bee Sting	☐	☐
Food	☐	☐
Medicine	☐	☐
Environmental	☐	☐
Required medication: _____		
Asthma	☐	☐
Medication: _____		
Frequency per year _____		
Attention Deficit Disorder	☐	☐
Medication: _____		
Convulsions/Seizures	☐	☐
Type: _____		
Medically controlled	☐	☐
Medication: _____		
Date of last episode: _____		
Diabetes	☐	☐
Type: _____		
Medication: _____		
Hearing Loss	☐	☐
Right ear percentage	_____	
Left ear percentage	_____	

	Yes	No
Heart Disorders	☐	☐
List: _____		
Medication: _____		
Orthopedic Problems		
List: _____		
Vision Problems	☐	☐
List: _____		
Correctable	☐	☐
Glasses/contacts required	☐	☐
Other Illnesses/Vaccinations	☐	☐
Chickenpox/Varicela Vaccine	☐	☐
Encephalitis	☐	☐
Meningitis	☐	☐
Hepatitis	☐	☐
Last TB test result	_____	_____
Last tetanus	_____	_____
Any other health/medical concerns	☐	☐
List: _____		

I have examined the patient listed above and listed all known health concerns.

_____ _____ _____

Physicians Signature | Printed Name | Date

Physician office address or stamp: _____

_____

_____

Revised 1/2011