MEDICAL BACKGROUND

Medical Insurance _____ Policy Number _____

Name in which insurance is carried. _____

Do you have any allergies? _____

Are you currently under a doctor's care or supervision? _____

Are you on any type of medication? (Indicate type and reason) _____

Do you have any type of physical limitation which would limit your ability to sit or stand for extended lengths of time? _____

Do you have any other medical problems, not yet indicated, that the Explorer Post should know about? _____

Applicant Signature_____ Date_____

Parent Authorization and Emergency Consent

The above health history information is correct and complete so far as I/we know and is based upon that of a licensed physician or chiropractor. The above minor has permission to engage all activities as noted for the period of one year from the date below. I/We certify that the above minor is physically fit. I/We know of no reason why he/she should not participate in any activity except as noted above.

I/We, the undersigned, parent(s)/guardian(s) of the above minor, do hereby authorize the activity leader(s) or responsible person(s) in charge to act as agent(s) for the undersigned, to consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the minor which is deemed advisable by, and is rendered under the general special supervision of, physician or surgeon, or any dentist, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere. Similar permission is granted to said agent(s) to authorize preliminary examination, diagnosis and first aid treatment. Similar permission is granted to said agent(s) to authorize preliminary examination, diagnosis and first aid treatment by first aid staff members. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned first aid staff member, physician or dentist, in the exercise of his best judgment, may deem advisable. This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of the State of California. This authorization shall remain in effect for the period of one year from the date below unless sooner revoked, in writing and delivered to said agent(s) and will be in effect while the above minor is en route to or from or involved or participating in any Explorer program or activity.

Signature_____ Date_____

Signature_____ Date_____