Pathfinder Health Record

Pathfinder Name _____

Birth Date _____

Complete the Following:

If yes to any of the following, please check and elaborate below or on a separate sheet of paper:

____Frequent Sore Throats	____Diabetic	____Convulsions/Seizures
____Frequent Ear Infections	____Rheumatic Fever	____Asthma/Lung Problems
____Heart Defects/Disease	____Stomach Problems	____Bleeding/Clotting
____Sickle Cell Disease/Threat	____Kidney Problems	____Sleepwalking
____Mononucleosis	____False/Capped Teeth	____Bed-wetter
____Glasses/Contacts	____Sinusitis	____Other_____

Allergies – Describe type of allergy and reactions and specify drug/medication names:_____

_____

Current Medications:_____

Date of last Tetanus Immunization/Booster:_____ Permission to Administer? ____Yes ____No

Approved over-the-counter medications:_____ Permission to Administer? ____Yes ____No

Physical Restrictions/Abnormalities – Describe:_____

Father's Name_____ Home Phone _____ Cell Phone _____

Work Phone_____ E-mail _____

Address_____ City_____ State_____ Zip_____

Mother's Name_____ Home Phone_____ Cell Phone_____

Work Phone _____ E-mail _____

Address_____ City_____ State_____ Zip_____

Emergency Contact Name & Phone (friend or relative) _____

Family Physician Name_____

Family Physician Address_____ City _____ State_____ Zip _____

Family Physician Phone(s)_____

Pathfinder insurance coverage is to cover medical expenses up to a capped amount per person for injuries that occur to a Pathfinder or Pathfinder Staff Member while such a person is attending an approved Pathfinder event or activity. Therefore, the above-named Pathfinder's family health insurance is:

Insurance Company_____

Insurance Policy Number_____

(Please attach a photocopy of the front and back of your family insurance card.)

To make a claim for an injury sustained at a Pathfinder event, use the form found in the Illinois Pathfinder Directors Manual.

Authorization to Treat a Minor

In the event emergency medical treatment becomes necessary for my child, we/I grant _____ (Pathfinder club director) or his/her assistants authority to obtain such emergency medical assistance. We/I further grant permission for medical personnel to administer emergency medical treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the above-named director or to the club entrusted with the custody of said minor.

_____ _____

Date *Parent/Guardian Signature*