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