



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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Convulsions/Seizures |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma/Lung Problems |
| <input type="checkbox"/> Heart Defects/Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Bleeding/Clotting |
| <input type="checkbox"/> Sickle Cell Disease/Threat | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> False/Capped Teeth | <input type="checkbox"/> Bed-wetter |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> 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