PATHFINDER HEALTH INFORMATION FORM

Pathfinder's Full Legal Name:____ **Date of Birth:**_____________________

Home Phone:____________________ **Grade:**_____________ **Age:** __________ **Gender:** _____ **Male** _____ **Female**

Address:____

Father's Name:____________________________ **Phone:**______________ **Email:**________________________________

Mother's Name:___________________________ **Phone:**______________ **Email:**________________________________

Alternate Emergency Contacts (Parents will be contacted first)

Name:_______________________________________ **Relationship to Pathfinder:**______________________________

Best Phone Number:_____________________________

Name:_______________________________________ **Relationship to Pathfinder:**______________________________

Best Phone Number:_____________________________

Pathfinder Doctor/Dentist Information

Physician:_________________________________ **City/State:**__________________ **Office Phone:**________________

Dentist:___________________________________ **City/State:**__________________ **Office Phone:**________________

Pathfinder Health Insurance Information

Health Insurance Company:____

Policy Holder:___________________ **Employer:**_____________________________ **City/State:**____________________

Policy Holder Birthdate:___________________ **Policy/Member #:**____________________ **Group #:**______________

Attach copy of Insurance Card

It is our desire to provide the best health care for your Pathfinder while he/she is with us. This form is to be completed and signed by the parent or guardian who name appears above.

No Pathfinder can be accepted without this form

The health history attached is correct and the person herein described has permission to engage in all prescribed activities, except as noted by me and/or the physician. In the event I cannot be reached in an emergency, I hereby give my permission to the physician in charge to hospitalize, secure proper anesthesia, or order injection or surgery for my son/daughter. I also give permission to the nurse or Pathfinder Staff Representative to give over-the-counter medications as listed on the attached, including by not limited to pain medication, and cold and flu medication unless otherwise noted. I understand that every effort will be made to contact me if my child is ill or injured. A photo copy of this authorization shall be as valid as the original.

Parent/Guardian Signature:____ **Date Signed:**______________________

PATHFINDER HEALTH INFORMATION FORM

Pathfinder Name:____

Please help us make your child's Pathfinder experience even safer by completing ALL of the Pathfinder Medical Information.

____ Asthma	____ Dental braces	____ Hypglycemia (low blood sugar)
____ Chickenpox	____ Dental retainer	____ Migraines (diagnosed by Doctor)
____ Diabetes	____ Eyeglasses	____ Mumps
____ Headaches	____ Contacts	____ Tuberculosis
____ Fainting Spells	____ Hearing Aids	____ Other
____ Ringing in Ears	____ Swimmer's Ear	Specify______________________
____ Heart Condition	____ Ear Tubes	____________________________
Specify___________________	____ Measles	____________________________

List all Allergies to medications, foods, or other including reactions to the allergen and treatment to provide:

____

____

____

Immunization Status:

Tetanus: ___________Month ________Year Chickenpox: ___________Month ________Year

Medications & Vitamins to be taken at Pathfinder Activities:

Medication Name	Dose	How Often	Reason	What happens if dose is missed?

Over-the-Counter Medications will be available while your child is at Pathfinder activities if needed. The medication supply includes but not limited to the list below. These medications may be administered under the direction of the club nurse or Pathfinder Staff Representative. Dosages will be as listed on labels. Generic equivalents may be used if available. Please check YES if you approve or NO if you do not approve of the medication being used (for each medication):

YES	**NO**		YES	NO	
____	____	Tylenol (minor aches/pains, fever)	____	____	Benadryl (congestion, allergic reactions)
____	____	Advil (minor aches/pains, cramps)	____	____	Tussin DM (cough)
____	____	Tums (upset stomach, nausea, indigestion)	____	____	Throat Lozenges (cough/sore throat)
____	____	Pepto-Bismol (same as above)	____	____	Imodium (diarrhea)
____	____	Topical Ointments (aloe vera, antibiotic ointment, hydrocortisone, etc)	____	____	Other :______________________________

List any other health related information you deem necessary:______________________________________

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