Health and Medical Record/Release

IDENTIFICATION

Name ______________________ Age __________ Birth Date ____________________

Address ______________________________________ Phone ______________

City ______________________ State __________ Zip ________ ☐Male ☐Female

Religion ______________________________________

HEALTH HISTORY

Have you had any of the following conditions? Mark "past" or "now" or leave blank if never had.

_______ Asthma
_______ Hay Fever
_______ Sinus Trouble
_______ Ear Ache/Infection
_______ Ear Tubes
_______ Fainting Spells
_______ Tuberculosis
_______ Bedwetting
_______ Kidney Disease
_______ Constipation
_______ Frequent Diarrhea
_______ Severe Stomach Ache
_______ Diabetes
_______ Sleeping Walking
_______ Epilepsy
_______ Rheumatic Fever
_______ Heart Trouble
_______ Glasses
_______ Contact Lenses
_______ Menstrual Cramps

ALLERGIES OR ALLERGIC REACTIONS (Check if yes and tell what the symptoms are)

☐ Penicillin ______________________________________

☐ Other Medications (List): ______________________________

☐ Bee Sting ______________________________________

☐ Poison Oak, Poison Ivy ______________________________

☐ Other: List ________________ ________________

________________ ________________

________________ ________________

PLEASE LIST ALL SERIOUS ILLNESSES OR OPERATIONS IN THE PAST FIVE YEARS

Operation or Illness	Date	Hospitalized? (yes/no)

MEDICATIONS: PLEASE LIST, IN AS MUCH DETAIL AS POSSIBLE, ANY/ALL MEDS THAT THE PATHFINDER IS TAKING.
PRESCRIPTION / NON-PRESCRIPTION / OVER-THE-COUNTER MEDICINE / VITAMINS / HOME REMEDIES / HERBS / ETC.

Medication	Dose (eg. mg/pill)	How many times per day?	Date started?

IMMUNIZATION HISTORY

Required immunizations must be determined locally. This is a record of dates of being immunized and most recent booster doses.

DTP Series ______________ Booster ______ Tetanus Booster______________

Polio OPV (Sabin) ______________ Booster ______ Tuberculin Test______________

Measles Vaccine (live) ______________ Mumps Vaccine (live)______________

German Measles (Rubella) ______________ Chicken Pox______________

DIET ☐ Vegetarian ☐ Diabetic ☐ Vegan

☐ Food Allergies ______________________________________

PHYSICAL ACTIVITY

Any restriction of activity for medical reasons? Explain:____

____

Any other type of health concerns which might be pertinent____________________________________

____

INFORMATION IN CASE OF ACCIDENT OR ILLNESS

Father/Guardian ____Phone (H) __________________

Home Address ____ Cell ______________________

____

Work Address ____ Phone (W) __________________

____

Mother/Guardian____ Phone (H) __________________

Home Address ____ Cell ______________________

____

Work Address ____ Phone (W) __________________

____

IF NOT AVAILABLE, IN EMERGENCY NOTIFY:

Name ______________________________

Address ______________________________

____

Phone (H) ______________ (W) ______________

Name ______________________________

Address ______________________________

____

Phone (H) ______________ (W) ______________

DOCTOR TO CONSULT IN CASE OF EMERGENCY

Name ______________________________ Phone (_______)____________________

Address ______________________________ City ____________________________

____________________________________ State ______________ Zip ______________

DO YOU HAVE MEDICAL INSURANCE ☐ Yes ☐No Number ____________________ Type Coverage ____________________

Company Name ____

Parent's Authorization*—required for those under 18 years of age.*

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my child.

Parent/Guardian's Signature ____________________________

Date ______________________________________

Subscribed and sworn to before me this
________ day of ______________________

____

Notary Public

My commission expires ________________