HEALTH AND MEDICAL RECORDS



Name		_ DOB:	Age:		
Male Female _	Home Phone:	Mobile	Mobile Phone		
Address:					
City:		State:	_Zip		
Pathfinder Club Nar	me:				
Health History	Have you had or curre	ently have:			
☐ Asthma	☐ Earache/Ear Trouble	☐ Glasses	☐ Rheumatic Fever		
☐ Bed wetting	☐ Ear Tubes	☐ Hay Fever	☐ Severe Stomachaches		
☐ Constipation	☐ Epilepsy	☐ Heart Trouble	☐ Sinus Trouble		
☐ Contact Lenses	☐ Fainting Spells	☐ Kidney Disease	☐ Sleep Walking		
☐ Diabetes	☐ Frequent Diarrhea		·		
Allergies or Allergio	: Reactions (Check if yes and	d tell what happened)			
Food					
☐ Poison Oak/Ivy					
Other Allergies (list)					
Please List All Serio	ous Illnesses or Operation	ns in the Past Five Yea	rs		
Operation or il		Date 	Hospitalized (yes or no		
					
	ications Currently Being		fan Taliaa		
Medication	Date	Reason	for Taking		
Physical Activity Any restriction of activi	ty for medical reasons? Explai	in			
	th concerns, which might be p				
Any unusual behaviors	(nightmares, sleep talking)				

Immunization History

Required immunizations must be determined locally. This is a record of basic immunizations and most recent Boosters.



Insurance Name Group # Member: Member #: PARENT'S AUTHORIZATION-required for those under 18 years of age. This health history is correct so far a I know, and the child named above has permission to engage in all activities, except as noted herein by me Exceptions (if any) In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photocopy of this shall be as valid as the original.	Check		Date	Check	Check			
DPT Series Booster Chicken Pox Mumps Vaccine (live) Does over (Sabin) Booster Mumps Vaccine (live) Oregon Residents: Does your child meet current Oregon State law for school attendance? Medical Exemption Religious Exemption Diet Regular Diabetic Low Salt Low Fat/Cholesterol Vegan Other More Fat/Cholesterol Notify in Case of Accident or Illness Parent/Guardian/Spouse Home Address Home Phone Work Phone If contact listed above is not available, in emergency notify: Name: Relationship to Pathfinder Address Home Phone Work Phone Doctor in Case of Emergency Name: Work Phone Doctor in Case of Emergency Name: Members Medical Insurance? Yes No Insurance Name Group # Member: Member: Member #: PARENT'S AUTHORIZATION-required for those under 18 years of age. This health history is correct so far at I know, and the child named above has permission to engage in all activities, except as noted herein by me Exceptions (if any) In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photocopy of this shall be as valid as the original.	☐ Measles Vaccine (live)							
Polio OPV (Sabin) Booster Mumps Vaccine (live)				🗆 Tubero	☐ Tuberculin Test			
Oregon Residents: Does your child meet current Oregon State law for school attendance? Medical Exemption Religious Exemption Diet Regular Diabetic Low Salt Low Fat/Cholesterol					Chicken Pox			
Diet Regular Diabetic Low Salt Low Fat/Cholesterol Vegan Other				\square \square Mumps Vaccine (live)				
Diet	•		agan Stata law far cab	a al attandance	2	.tion	□ Deligious Evenn	⊢an
Notify in Case of Accident or Illness Parent/Guardian/Spouse Home Address Home Phone Work Phone Work Phone If contact listed above is not available, in emergency notify: Name: Relationship to Pathfinder Address Home Phone Work Phone Doctor in Case of Emergency Name: Home Phone Work Phone Do You Have Medical Insurance? Yes No Insurance Name Group # Member: Member: Member #: PARENT'S AUTHORIZATION-required for those under 18 years of age. This health history is correct so far at 1 know, and the child named above has permission to engage in all activities, except as noted herein by me Exceptions (if any) In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photocopy of this shall be as valid as the original.	Does your (chila meet current Or	egon state law for sch	ooi attenuance	r 🗆 iviedicai exemp	otion	□ Keligious Exemp	uon
Parent/Guardian/Spouse Home Address Home Phone	Diet	J			•			
Home Address Home Phone Work Phone If contact listed above is not available, in emergency notify: Name: Relationship to Pathfinder Address Home Phone Work Phone Doctor in Case of Emergency Name: Work Phone Do You Have Medical Insurance? Yes No Insurance Name Group # Member: Member #: PARENT'S AUTHORIZATION-required for those under 18 years of age. This health history is correct so far at I know, and the child named above has permission to engage in all activities, except as noted herein by me Exceptions (if any) In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photocopy of this shall be as valid as the original.	Notify i	n Case of Acci	dent or Illness					
Home Address Home Phone Work Phone Work Phone If contact listed above is not available, in emergency notify: Name: Relationship to Pathfinder Address Home Phone Work Phone Doctor in Case of Emergency Name: Address Home Phone Work Phone Do You Have Medical Insurance? Yes No Insurance Name Group # Member: Member: Member #: PARENT'S AUTHORIZATION-required for those under 18 years of age. This health history is correct so far at I know, and the child named above has permission to engage in all activities, except as noted herein by me Exceptions (if any) In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photocopy of this shall be as valid as the original.	Parent/G	iuardian/Spouse						
Home Phone								
Name:								
Name:								
Address Home Phone	If conta	ct listed above	e is not availak	le, in eme	ergency notify	:		
Doctor in Case of Emergency Name:	Name: _				Relationship to P	Pathfir	nder	
Doctor in Case of Emergency Name:	Address							
Name:Address								
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Signature Date Parent or Guardian	I know, a Exception In the ev selected	nd the child namns (if any) ent I cannot be reby the adult lead	ed above has perre eached in an emere er in charge to ho	rgency, I her spitalize, se	ngage in all activi eby give permissi cure proper anes	ties, e _· ion to thesia	except as noted h	erein by me. vider
	Signature	Parent or	Guardian		Date			