HEALTH AND MEDICAL RECORDS

Name _____ DOB: _____ Age: _____

Male ____ Female ____ Home Phone: _____ Mobile Phone _____

Address: _____

City: _____ State:_____ Zip _____

Pathfinder Club Name: _____

Health History Have you had or currently have:

- ☐ Asthma
- ☐ Bed wetting
- ☐ Constipation
- ☐ Contact Lenses
- ☐ Diabetes
- ☐ Earache/Ear Trouble
- ☐ Ear Tubes
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Diarrhea
- ☐ Glasses
- ☐ Hay Fever
- ☐ Heart Trouble
- ☐ Kidney Disease
- ☐ Menstrual Problems
- ☐ Rheumatic Fever
- ☐ Severe Stomachaches
- ☐ Sinus Trouble
- ☐ Sleep Walking
- ☐ Tuberculosis

Allergies or Allergic Reactions (Check if yes and tell what happened)

☐ **Medications** _____

☐ **Bee Sting** _____

☐ **Food** _____

☐ **Poison Oak/Ivy** _____

☐ **Other Allergies (list)** _____

Please List All Serious Illnesses or Operations in the Past Five Years

Operation or illness	Date	Hospitalized (yes or no)
_____	_____	_____
_____	_____	_____

Please List All Medications Currently Being Taken

Medication	Date	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical Activity

Any restriction of activity for medical reasons? Explain

_____

Any other types of health concerns, which might be pertinent?

_____

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.

Check	Date	Check	Date
☐ Measles Vaccine (live)	_____	☐ Tetanus Booster	_____
☐ German Measles (Rubella)	_____	☐ Tuberculin Test	_____
☐ DPT Series_____ Booster	_____	☐ Chicken Pox	_____
☐ Polio OPV (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 _____

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: _____

Address _____

Home Phone _____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 as 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.

Signature _____ Date _____
Parent or Guardian