

Washington Conference Pathfinders  
HEALTH AND MEDICAL RECORDS

**1. Pathfinder Identification:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Male: \_\_\_\_\_ Female: \_\_\_\_\_ email: \_\_\_\_\_

**2. Health History**

Have you had: (Mark "Past" or "Now" or leave blank.)

_____ Asthma	_____ Bedwetting	_____ Epilepsy
_____ Hay Fever	_____ Kidney Disease	_____ Rheumatic Fever
_____ Sinus Trouble	_____ Constipation	_____ Heart Trouble
_____ Earache/Ear Infection	_____ Frequent Diarrhea	_____ Glasses
_____ Ear Tubes	_____ Severe Stomachaches	_____ Contact Lenses
_____ Fainting Spells	_____ Diabetes	For Women:
_____ Tuberculosis	_____ Sleep Walking	_____ Menstrual Problems

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

\_\_\_\_\_ Penicillin: \_\_\_\_\_  
\_\_\_\_\_ Other Medications (list): \_\_\_\_\_  
\_\_\_\_\_ Bee Sting: \_\_\_\_\_  
\_\_\_\_\_ Food: \_\_\_\_\_  
\_\_\_\_\_ Poison Oak, Poison Ivy: \_\_\_\_\_  
\_\_\_\_\_ Other (list): \_\_\_\_\_

**4. Please list all serious illnesses or operation in the past five years:**

Operation or Illness	Date	Hospitalized? (Yes/No)
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\_\_\_\_\_  
\_\_\_\_\_

**5. Please list all medications currently being taken:**

Medication	Number of Times in a Day	Reason for Taking
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(over)

**6. Immunization History**

Required immunizations must be determined locally. This is a record of basic immunizations and most recent booster doses. List the most recent date.

DTP Series \_\_\_\_\_ Booster \_\_\_\_\_ Tetanus Booster \_\_\_\_\_

Polio OPV (Sabin) \_\_\_\_\_ Booster \_\_\_\_\_ Tuberculin Test \_\_\_\_\_

Measles, Mumps, Rubella (MMR) \_\_\_\_\_ Chicken Pox \_\_\_\_\_

Hepatitis B \_\_\_\_\_ H. Influenza Type B (Hib) \_\_\_\_\_

**7. Diet** \_\_\_\_\_ Regular \_\_\_\_\_ Diabetic \_\_\_\_\_ Low Salt \_\_\_\_\_ Low Fat/Cholesterol  
\_\_\_\_\_ Vegetarian Other Special Instructions: \_\_\_\_\_

**8. Physical Activity**

Any restriction of activity for medical reasons? Explain: \_\_\_\_\_

**9. Inform in case of accident or illness:**

Parent/Guardian/Spouse \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If not available, in emergency notify:

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

or

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**10. Doctor to consult in case of emergency**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**11. Do you have?**

Medical Insurance? \_\_\_ YES \_\_\_ NO If yes, number \_\_\_\_\_

Type of 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 the physician and me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Club Director in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my son (or daughter). A photocopy of this shall be as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent or Guardian*