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)

5. Please list all medications currently being taken:

Medication	Number of Times in a Day	Reason for Taking

(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