

Pathfinder Health Record & Consent to Treatment



Name of Minor _____

Address _____
Street Address City, State, Zip

Birth Date ____/____/____
Month Day Year

Date of last Tetanus Booster ____/____/____
Month Day Year

List all allergies to drugs, food, other: _____

List current medications or pertinent medical information: _____

List any restrictions on activities, etc: _____

Name(s) of Parent(s)/Legal Guardian(s) _____

Parent/Guardian Home Phone _____ Parent/Guardian Work Phone _____

Parent/Guardian Cell Phone _____ Parent/Guardian Other Phone _____

Emergency Name & Phone (friend/relative) _____
Name Phone Relationship to child

Family Physician Name _____

Family Physician Address _____
Street Address City, State, Zip

Family Physician Phone _____

Insurance Company Name _____

Insurance Policy Number _____ Group Number _____
(Please attach photocopy of insurance card)

Authorization and Consent to Medical Treatment of a Minor:

I (we) the undersigned parent(s) or legal guardian of _____
Name of Minor

hereby give permission to the physician selected by the group leader to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child in the event it becomes necessary in an emergency. This may include x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, medications (over-the counter as well as prescribed) and hospital service that may be rendered to said minor. It is understood that this consent is given in advance of any specified diagnosis or treatment which might be required and is given to authorize the physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment. As parent/legal guardian, I am in favor of my child attending/participating in Pathfinder events and accept the conditions named herein. This health history stated is correct so far as I know, and my child has my permission to engage in all prescribed club activities except as noted above. In addition, I have read and understand this Emergency Authorization statement and give my full consent to the terms found therein. Permission for photocopying of this health record is granted and a photocopy shall be as valid as the original.

Date

Parent / Guardian Signature

Signature of Witness

NOTE: This completed form is to be kept on file at the local Pathfinder Club. A copy must be brought on every Pathfinder outing or trip.

Revised 8/13/08