Meadow Glade Pathfinder
Health Information Form 2014 - 2015

Pathfinder's Full Legal Name

Birthday

Home Phone Number

Grade

Age

Gender
M ☐ F ☐

Address

City

State

Zip Code

Father's Name

Work Phone

Cell Phone

Email

Mother's Name

Work Phone

Cell Phone

Email

Emergency Contacts (will be contacted in order listed)

(1) Name

Relationship

Home Phone

Cell Phone

Work Phone

(2) Name

Relationship

Home Phone

Cell Phone

Work Phone

(3) Name

Relationship

Home Phone

Cell Phone

Work Phone

Pathfinder Doctor/Dentist Information

Physician

City/State

Office Phone

Dentist

City/State

Office Phone

Pathfinder Health Insurance Information

Insurance Company

Employer

City/State

Policy Holder

Birthdate

Policy/Member Number

Group Number

Pathfinder Medical Information

Please help us make your child's Pathfinder experience even safer by completing ALL of the Pathfinder Medical Information.

- ☐ Asthma
- ☐ Chickenpox
- ☐ Dental braces
- ☐ Dental retainer
- ☐ Diabetes
- ☐ Ear Tubes
- ☐ Eye glasses
- ☐ Contacts
- ☐ Fainting Spells
- ☐ Headaches
- ☐ Hearing Aid
- ☐ Heart Condition
  - Specify ____
- ☐ Hypoglycemia (Low Blood Sugar)
- ☐ Measles
- ☐ Migraines (diagnosed by Doctor)
- ☐ Mumps
- ☐ Ringing in Ears
- ☐ Seizures
- ☐ Swimmers Ear
- ☐ Tuberculosis
- ☐ Other ____

Allergies

Medication	Reaction	Treatment

Food	Reaction	Treatment

Other	Reaction	Treatment

Immunization Status:

Tetanus:	Month		Year	
Chickenpox:	Month		Year	

Pathfinder Name: ____

Medications & Vitamins to be taken at Pathfinder activities

Medication Name	Dose	How Often	Reason	What happens if dose is missed?

Over-the-counter medications will be available while your child is at Pathfinder activities if needed. The medication supply includes, but is not limited to the list below. These medications may be administered under the direction of the club nurse. Dosages will be as listed on labels. Generic equivalents may be used if available. Please check YES if you approve or NO if you do not approve of the medication being used (for each medication):

Yes	No		Yes	No	
☐	☐	Tylenol (minor aches/pains, fever)	☐	☐	Benadryl(congestion, allergic reactions)
☐	☐	Advil (minor aches/pains, cramps)	☐	☐	Tussin DM (cough)
☐	☐	Tums(upset/stomach/nausea/ indigestion)	☐	☐	Throat Lozenges
☐	☐	Pepto-Bismol (same as above)	☐	☐	Imodium (diarrhea)
☐	☐	Topical Ointments (aloe vera, antibiotic ointment, Hydro cortisone, etc)	☐	☐	Other

*It is our desire to provide the best health care for your pathfinder while he/she is with us. This form is to be completed and signed by the parent or guardian whose name appears on the front page.

No pathfinder can be accepted without this form.

This health history is correct and the person herein described has permission to engage in all prescribed activities, except as noted by me and/or the physician. In the event I cannot be reached in an emergency, I hereby give my permission to the physician in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my son/daughter. I also give permission to the nurse to give over-the-counter medications as listed above including but not limited to pain medication, cold and flu medication unless otherwise noted. I understand that every effort will be made to contact me if my child is ill or injured. A photo copy of this authorization shall be as valid as the original.

*____________________ ____________

Parent/Guardian's Signature Date