LAKE REGION CONFERENCE

Youth Ministries Department

Health and Medical Record Form 3 - page 1

Pathfinder Identification Information

Name of Pathfinder									
Age		Birth Date		Male		Female		SS No.	
Mailing Address				City/St/Zip					
Best Phone No.(s)	1.		2.			Email			
Church Affiliation				Religion					

Health History

Please check all boxes that applies and circle "Yes" or "No" if you presently have currently.

☐ Asthma	Y/N	☐ Bedwetting	Y/N	☐ Epilepsy	Y/N	☐ Hay Fever	Y/N
☐ Rheumatic Fever	Y/N	☐ Kidney Disease	Y/N	☐ Simus Trouble	Y/N	☐ Constipation	Y/N
☐ Heart Trobule	Y/N	☐ Ear Aches	Y/N	☐ Ear Infection	Y/N	☐ Diarrhea	Y/N
☐ Glasses	Y/N	☐ Ear Tubes	Y/N	☐ Stomach Aches	Y/N	☐ Contact Lenses	Y/N
☐ Fainting Spells	Y/N	☐ Diabetes	Y/N	☐ Menstrual Problems	Y/N	☐ Tuberculosis	Y/N
☐ Sleep Walking	Y/N	☐ Other _____	Y/N	☐ Other _____	Y/N	☐ Other _____	Y/N

Allergies or Allergic Reactions (Check if YES and tell what happens)

☐ Penicillin _____

☐ Other Medication (list) _____

☐ Bee Sting _____

☐ Food _____

☐ Poison Oak, Poison Ivy _____

☐ Other - List _____

☐ Other - List _____

☐ Other - List _____

☐ Other - List _____

Please list all Serious Illnesses or Operations

Operation or Illiness		Date		Hospitalized? Yes/No

Please Isit all Medication(s) Currently Being Taken

Medication Name		Number of Times in Day		Reason for Taking

Diet Needs

☐ Regular ☐ Diabetic ☐ Low Salt ☐ Low Fat/Cholesterol

☐ Other - Special Insturctions:

Health and Medical Record Form 3 - page 2

Immunization History

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

Medication Name	Date	Medication Name	Date	Medication Name	Date
* DTP Series		* Tuberculin Test		* Polio OOPV (Sabin)	
* Mumps Vaccine		* Measles Vaccine		* Chicken Pox	
* German Measles		* Tetanus Booster		* Other Booster	

☐ Does your child meet current state law for school attendance? ☐ You have medical exemptions ☑ You have religious exemption

Physical Activity

Any restriction of activty for medical reason? Please explain	
Any other type of health concerns which might be partners?	

Who to Inform - In Case of Accident and/or Illness

Parent/Guardian/Spouse		Phone No.	
Home Address		Home Phone No.	
Work Address		Work Phone No.	

If above name(s) are not available in emergency - please notify:

Name & Relationship		Phone No.	
Home Address		Home Phone No.	
Work Address		Work Phone No.	
Name & Relationship		Phone No.	
Home Address		Home Phone No.	
Work Address		Work Phone No.	

Doctor to Consult in Case of Emergency

Doctor's Name		Phone No.	
Address		City/St/Zip	

Do You Have?

	Medical Insurance		Insurance Number		Type of Coverage	

Guardian's Authorization Required for Those under 18 Years of age

The information above is correc to the best of my knowledge

Parent and/or Guardian Signature	Date

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the adult leader to hospitalize, secure proper anesthesia, or to order injection or surgery for my son (for daughter.) A photostat copy of this shall be as valid as the original.

Parent and/or Guardian Signature	Date

Comments and/or Suggestions from Parent(s)