Medical Record Form
Kentucky-Tennessee Conference of Seventh-day Adventists
PATHFINDERS

Full Name _____ Birth Date _____ /_____ /_____

Prefers to be called _____

Home Address _____ Phone _____

City _____ State _____ Zip _____

Father's Name _____ Day Time Phone _____

Night Time Phone _____

Mother's Name _____ Day Time Phone _____

Night Time Phone _____

Emergency Phone _____ Relationship _____

Physician's Name _____ Phone # _____

Medical Insurance Company _____ ID Number _____

Does your child have a history of any of the following: (circle)

Heart Disease	Sleepwalking	Heart Murmur	Cancer
Asthma	Frequent Sore Throats	Bed Wetting	Hyperactivity
Kidney Disease	Constipation	German Measles	Bleeding Disorders/Hemophilia
Diabetes	Immune Deficiency	Menstrual Problems	Chicken Pox
Anemia	Emotional Disorders	Fainting	Rheumatic Fever
Nose Bleeds	Liver Disease	Upset Stomach	Headaches/Migraines
Measles	Hepatitis	Seizures/Convulsions	Athlete's Foot

Does your child have **Allergies** and what is the reaction? (ie. food, medicine, insect bites, plants, hay fever, or reactions to particular areas, etc) _____

_____

Is your child taking any medications regularly? _____ For what? _____

Name of medication, dosage, & interval _____

Has your child ever been hospitalized? _____ If so, when? _____

Why _____

Does your child have any metal plates or pins in his/her body? _____ If so, where? _____

When was your child's last physical exam? _____

Is there any reason to restrict full activity, including, but not limited to, swimming, long hikes, or strenuous physical games? If so, explain _____

Date of Last Immunizations:

DPT (Diptheria, Pertussis, Tetanus) _____ Polio _____

MMR (Measles, Mumps, Rubella) _____ Hepatitis B _____

Tetanus (Last Booster) _____ Chickenpox _____

Does your child wear contact lenses? YES NO Removable dental appliances? YES NO

Does your child have any medical problems not covered above? _____

_____

Authorization to Treat a Minor

I (we) the undersigned parent, Parents or legal guardian of: *Name of Pathfinder* _____

In case of emergency, I understand that every reasonable effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, injections of medications, anesthesia or surgery for my child.

As a parent or legal guardian of the above named Pathfinder, I am in favor of him/her attending club functions and accept the conditions named. The health history given by me on this form (front and back) is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. In addition I have read and understand the emergency authorization statement and give my full consent to the terms found therein. Permission for photo copying of this health record is granted.

Signed _____

Relationship to child _____ **Date** _____

This section is for the notary to sign if your state requires it.