Medical Record Form
Kentucky-Tennessee Conference of Seventh-day Adventists
PATHFINDER STAFF

Full Name _____ Birth Date _____ /_____ /_____

Prefers to be called _____

Home Address _____ Phone _____

City _____ State _____ Zip _____

Spouse's Name _____ Cell Phone _____

Other Phone _____

Emergency Phone _____ Relationship _____

Physician's Name _____ Phone # _____

Medical Insurance Company _____ ID Number _____

Social Security Number _____

Do you have any medical problems: (circle)

Heart Disease	Immune Deficiency	Bleeding Disorders
Asthma	Emotional Disorders	Hypertension
Kidney Disease	Liver Disease	Diabetes
Hepatitis	Seizures/Convulsions	Anemia
Hemophilia	Cancer	Thyroid Disease

Allergies and what is the reaction? (i.e. food, medications, insect bites, plants, hay fever, or reactions to particular areas, etc) _____

_____

Medications regularly? _____ For what? _____

Name of medication, dosage, & interval _____

Have you ever been hospitalized? _____ If so, when? _____

Explain _____

When was your 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 _____

Do you wear contact lenses? YES NO Removable dental appliances? YES NO

Do you have any medical problems not covered above? _____

_____

Emergency Authorization to Treat

I, _____

In case of emergency, I understand that every reasonable effort will be made to contact my emergency contact. In the event that they cannot be reached and in life or death emergency, 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 me.

The health history given by me on this form (front and back) is correct so far as I know. 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 _____

Club Name _____

Date _____

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