Chapel West Eternal Flame Pathfinder Club
Pathfinder Health Record

Name: _____
Birthday: _____
Social Security Number: _____
Date of last Tetanus Booster: _____
Allergies to drugs or food:

Place copy of Insurance card here

Special Medications or pertinent information:

List of restrictions:

Father's home phone: _____ Father's work phone: _____

Mother's home phone: _____ Mother's work phone: _____

Emergency Phone (cell phone or friend or relative, please state type and who):
_____

Family Physician Name: _____

Family Physician Address: _____

Family Physician Phone: _____

Insurance Company: _____

Insurance Policy Number: _____

Authorization to treat minor

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

In case of emergency, I hereby give permission to the physician selected by the club directors to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child. As parent or legal guardian of the applicant, I am in favor of him/her attending club functions and accept that conditions named. The health history stated is correct so far as I know, and the person herein described has permission to engage in all prescribed club 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 photocopying of this health record is granted.

Date: _____ Parent/Guardian Signature: _____