

PATHFINDER HEALTH RECORD/CONSENT TO TREAT 2022-2023

Name_____

Birth Date_____

Date of last Tetanus Booster_____

Allergies to drugs or food:

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 Contact (Friend or relative)_____

Family Physician Name_____

Family Physician Address_____

Family Physician Phone_____

Insurance Company_____

Insurance Policy Number_____

Authorization to treat a minor:

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

In case of an 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 the 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 photo copying of this health record is granted.

Date

Parent/Guardian Signature

