

Carmichael Pathfinder Health Record

Name: _____ Date of birth: _____ Sex: M F

Address: _____

City: _____ State: _____ ZIP Code: _____

Date of Last Tetanus Booster: _____

Allergies to Drugs or Food: _____

Special Medications or Pertinent Information: _____

List of Restrictions: _____

Father or Guardian: _____

Home or Cell Phone: _____ Work Phone: _____

Mother or Guardian: _____

Home or Cell Phone: _____ Work Phone: _____

Emergency Contact Name of relative or friend: _____

Home or Cell Phone: _____ Work Phone: _____

Family Physician: _____

Phone: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

AUTHORIZATION TO TREAT A MINOR

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

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 a 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 to the best of my knowledge, 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.

Signature of Parent or Guardian: _____ Date: _____