KNOXVILLE 1ST PATHFINDERS

GCC Pathfinder Medical Record and Release

IDENTIFICATION

Pathfinder Name_____ Age_____ Birth Date_____

Mailing Address_____Home Phone_____

City_____ State_____ Zip _____Female _____Male_____

Club Director's Name _____

If a child, who has legal custody? ____Both parents ____Mother ____Father ____Other_____

HEALTH HISTORY

Have you had any of the following conditions?

___Asthma/wheezing	___Bed wetting	___Seizure Disorder
___Hay Fever	___Kidney Disease	___Rheumatic Fever
___Sinus Trouble	___Constipation	___Heart Condition
___Ear ache, Ear Infection	___Frequent Diarrhea	___Glasses/Contacts (circle)
___Ear Tubes	___Severe Stomach Ache	___Headaches
___Fainting Spells	___Diabetes	___Frequent Sore Throats
___ Sprains, dislocations, etc.	___Tuberculosis	*For Women:*
___Sleep Walking	___back or joint pain	___Menstrual Problems

ALLERGIES OR ALLERGIC REACTIONS (Check if yes, then tell what happened.)

___No Known Allergies
___Penicillin_____
___Other Medications (list) _____
___Bee Sting_____
___Food_____
___Poison Oak, Poison Ivy_____
___Other (list)_____

PLEASE LIST ALL SERIOUS ILLNESSES OR OPERATIONS IN THE PAST FIVE YEARS

Operation or Illness	Date	Hospitalized? (yes/no)
_____	_____	_____
_____	_____	_____

DIET ___Regular ___Diabetes ___Low Salt ___Low Cholesterol ___Other_____
Special Instructions _____

PHYSICAL ACTIVITY

Any restriction of activity for medical reasons? Please explain _____
_____
_____

IMMUNIZATION HISTORY

Are all your immunizations, required for school, up-to-date? ____Yes ____No

Tetanus Status: Month_____ Year _____ (The month and year of most recent Tetanus shot is **required**)

If applicant has not been fully immunized, please check and sign the following statement:

☐ I understand and accept the risks from my child not being fully immunized.

Legal Parent/Guardian's Signature: _____

MEDICATIONS

If Pathfinder has their own medications, all forms (prescribed or over-the-counter, vitamins, or natural remedies, etc.) must be kept and administered by staff. It must be brought in the original bottle and turned into the director by the parent/guardian. Please list any medications currently being taken by the Pathfinder below along with any special instructions.

____The applicant will **NOT** take any daily medications while attending events.
____The applicant will need to take the following medications while attending events.

Medication Name	Dosage	Frequency	Reason for Taking

Any Other Special Instructions _____
_____

ON-SITE TREATMENT
Please check any OTC (over the counter) meds that the staff **IS ALLOWED** to give the Pathfinder during events.

___Ibuprofen (Tylenol) - headache or pain
___Acetaminophen (Advil)- headache or pain
___Motrin (muscle pain)
___Bismuth subsalicylate (Immodium, Pepto-Bismol) - diarrhea
___Visine or clear eye drops (itching eyes)
___Mylanta, Maalox of Tums (upset stomach)
___Pseudoephedrine decongestant (Sudafed)
___Phenylephrine decongestant (Sudafed PE)
___Ointment for rash (Hydrocortisone)
___Aloe (burn)
___Antihistamine/allergy medication (Zyrtec/Claritin)
___Antibiotic Ointment (wound care)
___Charcoal tabs (upset stomach)
___Diphenhydramine antihistamine/allergy medication (Benadryl)
___Caladryl cream/Calamine lotion (itching)
___cough drops (cough)
___Throat Lozenges for sore throat
___Sore throat Spray (Chloraseptic)
___Guaifenesin cough syrup
___Dextromethorphan cough syrup
___Laxative for constipation

Any other type of health concerns which might be pertinent?_____
_____
_____

EMERGENCY CONTACT INFORMATION

Primary Contact in case of illness or injury for child it must be a Parent/Guardian with legal custody
Name_____
Relationship to Applicant_____
Primary Phone_____
Alternate Phone_____

2nd parent/guardian or other emergency contact (optional)
Name_____
Relationship to Applicant_____
Primary Phone_____
Alternate Phone_____

Additional contact in event parent/guardian(s) cannot be reached (optional)
Name_____
Relationship to Applicant_____
Primary Phone_____
Alternate Phone_____

Pathfinder's Physician_____Phone_____
Pathfinder's Dentist_____Phone_____
Pathfinder's Orthodontist _____Phone_____

Health Insurance Information

Medical Insurance? YES NO Policy Number_____ Group Number_____

Name of Company_____ Phone Number_____

Policy Holder_____ Holder's Birthdate: _____/_____/_____

Employer_____

***Please note: Health insurance remains the family's responsibility to provide.**

PARENT'S AUTHORIZATION FOR TREATMENT - required for those under 18 years of age.

This health history is correct and accurately reflects the health status of the applicant as far as I am aware. If a child, applicant will turn in all medications to the Director and will take any and all prescribed medications sent by the parent/guardian. I give permission to the designated staff to give over-the-counter medications as indicated in this document. If I cannot be reached in an emergency, I give permission to the physician selected by the designated staff to examine, order any x-rays or routine tests, to hospitalize, secure proper treatment, order injections, anesthetic, medical and/or surgical treatment to said minor. I understand the information on this form will be shared on a "need to know" basis with the staff. In addition, the staff have permission to obtain a copy of my/my child's medical record from providers who treat me/my child and these providers may talk to the attending staff about my/my child's health status. I hereby authorize any hospital or physician, or any other person who has attended or examined me/my child to furnish the insurance company or its representative any and all information with respect to any illness, injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records in regards to receiving payment for their services. I accept the conditions stated, including the release of the Georgia Cumberland Conference management from liability in case of serious illness, injury or death. I hereby give my consent for me/my child to participate in all activities. This consent shall remain in continuous effect until revoked in writing. A photocopy of this form shall be as effective and valid as the original.

Signature_____
***Applicant or Custodial Parent or Guardian's signature**

Relationship to Applicant_____

Date_____
***This form is to be completed and signed by the primary Parent/Guardian whose name appears on the second page of this document.**

Subscribed and sworn to before me this_____

day of_____

_____
Notary Public

My commission expires_____