HEALTH AND MEDICAL RECORDS

Name ____ Age ________ Birth Date _________

Address ____ Home Phone ________________

City _______________________________ State _______ Zip ____________ Male __ Female __

Pathfinder Club Name ____

Health History Have you had or currently have:

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Asthma	☐	☐	Earache/Ear Trouble	☐	☐	Glasses	☐	☐	Rheumatic Fever
☐	☐	Bed wetting	☐	☐	Ear Tubes	☐	☐	Hay Fever	☐	☐	Severe Stomachaches
☐	☐	Constipation	☐	☐	Epilepsy	☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	Contact Lenses	☐	☐	Fainting Spells	☐	☐	Kidney Disease	☐	☐	Sleep Walking
☐	☐	Diabetes	☐	☐	Frequent Diarrhea	☐	☐	Menstrual Problems (For Women Only)	☐	☐	Tuberculosis

Allergies or Allergic Reactions (Check if yes and tell what happened)

☐ **Medications**

____

☐ **Bee Sting**

____

☐ **Food**

____

☐ **Poison Oak/Ivy**

____

☐ **Other Allergies (list)**

____

Please List All Serious Illnesses or Operations in the Past Five Years

Operation or illness	Date	Hospitalized (yes or no)
______________________________	________________	__________
______________________________	________________	__________

Please List All Medications Currently Being Taken

Medication	Date	Reason for Taking
______________________	______________	______________________
______________________	______________	______________________
______________________	______________	______________________

Physical Activity

Any restriction of activity for medical reasons? Explain ______________________________________

____

Any other types of health concerns, which might be pertinent? __________________________________

____

Any unusual behaviors (nightmares, sleep talking) ____

Immunization History

Required immunizations must be determined locally. This is a record of basic immunizations and most recent Boosters.

Check	Date			Check	Date
☐ Measles Vaccine (live)	_____________			☐ Tetanus Booster	___________
☐ German Measles (Rubella)	_____________			☐ Tuberculin Test	___________
☐ DPT Series	_____________	Booster	____________	☐ Chicken Pox	___________
☐ Polio OPV (Sabin)	_____________	Booster	____________	☐ Mumps Vaccine (live)	___________

Oregon Residents: Does your child meet current Oregon State law for school attendance? ☐ Medical Exemption ☐ Religious Exemption

Diet ☐ Regular ☐ Diabetic ☐ Low Salt ☐ Low Fat/Cholesterol ☐ Vegan ☐ Other ________________

Inform in Case of Accident or Illness

Parent/Guardian/Spouse ____

Home Address ____Home Phone ________________

Work Address ____Work Phone ________________

If contact listed above is not available, in emergency notify:

Name____ Name ____

Address ______________________________________ Address ______________________________________

______________________________________ ______________________________________

Phone: Home ______________ Work ______________ Phone: Home _______________ Work ____________

Doctor to Consult in Case of Emergency

Name _____________________________________ Address_______________________________________

City _______________________________________ State _____ Zip ___________Phone__________________

Do You Have

Medical Insurance? _______________________ if yes, please provide Insurance Number ____________________

(Yes or No)

Insurance Name ____

PARENT'S AUTHORIZATION-required for those under 18 years of age or under 21 if still living at home.
This health history is correct so far as I know, and the child named above has permission to engage in all activities, except as noted herein by me. Exceptions (if any) ____. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photo copy of this shall be as valid as the original.

Signature _______________________________________ Date _______________________________

Parent or Guardian