

**Southern New England Conference of the Seventh-Day Adventist Church  
Adventurer Member Application & Consent for Treatment**

**I. Personal & Emergency Contact Information**

Applicant Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_/\_\_/\_\_\_\_  
 Adventurer Level Completed: Little Lamb  Eager Beaver  Busy Bee  Sunbeam  Builder  Helping Hand   
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender: M F  
 Church: \_\_\_\_\_ Baptized(SDA)  yes  no Baptism Date: \_\_/\_\_/\_\_\_\_

**Parent/Guardian Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Parent/Guardian Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Additional Contact in event parent(s)/guardian(s) cannot be reached:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**2. Allergies/Health History/Medical Insurance**

Physician's Name: \_\_\_\_\_ Physician's Phone Number: \_\_\_\_\_  
 Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Insured parent/guardian name: \_\_\_\_\_ Phone: \_\_\_\_\_

Does club member have any current physical, medical, or psychological conditions requiring medication, treatment, or special consideration or activity restrictions while participating in any Adventurer event?  Yes  No If yes, please explain below:

\_\_\_\_\_  
 \_\_\_\_\_

Check Yes or No for each statement. Explain "yes" answers below.

	Y	N		Y	N
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Had fainting or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Passed out/had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have a recurrent/chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Had a recent infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Traveled outside the U.S. in the past 9 months?	<input type="checkbox"/>	<input type="checkbox"/>
Had a recent injury?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with falling asleep/sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Had asthma/wheezing/shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had back/joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have diabetes? Type 1 Type 2?	<input type="checkbox"/>	<input type="checkbox"/>	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
Had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Have a problem with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Had headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have impaired vision?	<input type="checkbox"/>	<input type="checkbox"/>	If female, have problems with menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "yes" response in the space provided. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Allergies: No known allergies

This Club member is allergic to:  Environment (e.g., insect bites, sun)  Food  Medicine  Other

Please describe below what the child is allergic to and their typical reaction.

\_\_\_\_\_  
\_\_\_\_\_

Does the Adventurer require medication administered for allergic reactions?  Benadryl/Diphenhydramine  Epi Pen Other: \_\_\_\_\_

Date of last Tetnus immunization/booster: \_\_\_/\_\_\_/\_\_\_ Permission to administer Tetanus in an emergency?  Yes  No

### 3. Consent to Administer Medication and or Treatment

I give consent for \_\_\_\_\_ Adventurer Club to administer and/or supervise self administration of medication for the following over the counter and prescription medication to my child.

Please call first prior to administering any medication.

#### Over the Counter Medications

- Acetaminophen
- Ibuprofen
- Benedryl/Diphenhydramine
- Cough Syrup
- Tums

#### Prescription Medication

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

My child is currently taking the following medication:

Name of Medication	Dosage	Frequency	Reason for taking medication

Should the medication or dosage required change while the participant is registered in the program, it is the Parent/Legal guardian's responsibility to make the necessary revisions to this form or to complete a new form immediately.

1. All prescriptions shall be maintained with the child's name and shall be dated
2. Prescription medication must be stored in the original bottle with unaltered label. Medication requiring refrigeration must be properly stored.
3. Prescription and non-prescription medication shall be administered according to the label directions.

I fully acknowledge that while all precautions for the safe administration of medication will be taken \_\_\_\_\_ Adventurer Club are not medically qualified to supervise this duty and that inherent in this, there may be risks or hazards for which I will not hold SNEC or any of its representatives responsible. I will also agree that I will ensure that all medication I provide for my child during any events has not expired and will be provided to the staff at time of events and picked up and maintained at home. No medication will be held on the premises outside of meetings and events.

I/we the parent/guardians hereby give my consent for the above named child to participate in the \_\_\_\_\_ Adventurer year. I/we am aware that my child may at some point require emergency medical treatment as a result of accident or sickness. In the event emergency medical treatment become necessary for my child, I/we grant permission to \_\_\_\_\_ Adventurer Club Director and staff authority to obtain such emergency medical assistance. I/we further grant permission for medical personnel to administer emergency medical treatment.

#### 4. Approval by Parent/Legal Guardian for Club Membership

The applicant must be in grades five through 10 to become an Adventurer.

We will assist the applicant in observing the rules of the Adventurer Organization. In consideration of the benefits derived from membership, we hereby wave any claim against the club or the Southern New England Conference of the Seventh Day Adventist Church for any accidents that may arise in connection with the activities of the Adventurer Club.

As Parents/Legal Guardians we understand that the Adventurer Club program is an active one of the applicant. It includes many opportunities for service, adventure and fun. We will cooperate:

1. By learning how we can assist the applicant and his/her leaders.
2. By encouraging the applicant to take an active part in all activities.
3. By attending events to which parents are invited.

Please be advised that the activities of this club will be recorded using pictures, videos, and brief summaries of participation in events/activities for use in club/conference websites, newsletters, marketing materials, presentations, and social media (including but not limited to: Facebook, YouTube, Twitter, Snapchat, Instagram etc.)

**By signing this form, I declare that I have read and understand the contents of this form and agree to all the terms and conditions herein.**

**I declare that I am the legal parent and/or guardian of the child listed above and that I am authorized to sign this document. The information I have provided is truthful and accurate to the best of my knowledge.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

I would like to join \_\_\_\_\_ Adventurer Club . I will attend club meetings, hikes, camping and field trips, outreach and social activities, and any other club activities. I agree to be guided by the rules of the club and the Adventurer Pledge and Law.

**Adventurer Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_