

# 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

Asthma

Bed wetting

Constipation

Contact Lenses

Diabetes

### Past/Now

Earache/Ear Trouble

Ear Tubes

Epilepsy

Fainting Spells

Frequent Diarrhea

### Past/Now

Glasses

Hay Fever

Heart Trouble

Kidney Disease

Menstrual Problems  
(For Women Only)

### Past /Now

Rheumatic Fever

Severe Stomachaches

Sinus Trouble

Sleep Walking

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
<input type="checkbox"/> Measles Vaccine (live)	_____	<input type="checkbox"/> Tetanus Booster	_____
<input type="checkbox"/> German Measles (Rubella)	_____	<input type="checkbox"/> Tuberculin Test	_____
<input type="checkbox"/> DPT Series	_____ Booster _____	<input type="checkbox"/> Chicken Pox	_____
<input type="checkbox"/> Polio OPV (Sabin)	_____ Booster _____	<input type="checkbox"/> 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. 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 \_\_\_\_\_

Parent or Guardian

Date \_\_\_\_\_