Durham Trailblazers Pathfinder Club
Medical Information and Release Record 2019-2020

Please complete all information on both sides and use the fillable form if possible. If not, please PRINT CLEARLY.

Staff and Emergency Contact Information:

In the following section, please list the staff and spouse's name and contact information as well as an additional emergency contact person. The additional person will be notified if the spouse cannot be reached.

Staff's Name: _____ Date of Birth: _____ (d/m/y)

The club communicates with staff on a regular basis through email. Please indicate at which email addresses you would like to receive communication. Please keep your contact information up-to-date with Pathfinders should it change during the year.

Staff Info: Land Line: _____

Address: _____ Cell Phone: _____

City: _____ PC: _____ Work Phone: _____

Email: _____

Spouse Name: _____ Land Line: _____

Address: _____ Cell Phone: _____

City: _____ PC: _____ Work Phone: _____

Email: _____

Secondary Contact: _____ Land Line: _____

Relationship to Staff: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Staff's Health Record and Medical Information: (ALL information must be completed each year)

Pathfinder's Physician: _____ Office Phone: _____

Heath Card Number: _____ (must complete Dr. info and card # yearly)

History: (Allergies on reverse)

☐ Asthma	☐ Fainting	☐ Sinusitis	☐ Sore Throat
☐ Bed-wetting	☐ Heart Trouble	☐ Sleepwalking	☐ Stomach Upset
☐ Bronchitis	☐ Kidney Trouble	☐ Other:	_____
☐ Diabetes	☐ Seizures		_____

Special Dietary Requirements/Sensitivities other than vegetarian (Please be specific):

_____

_____

The health information stated above is correct so far as I know. Staff Initials: _____

Allergies:

Allergy to:	Specify:	Reaction:	Severity:	Antidote:
Animals				
Bees/Insects				
Drugs				
Foods				
Plants				
Other				

Medications: Are you currently taking medication on a regular basis? Yes ☐ No ☐

Drug Name:	Dosage:	Time:

Immunizations: Up to Date Exemption Letter

Permission to Administer Medications: (Check either Yes or No)

Acetaminophen (Tylenol)	Yes ☐	No ☐	May be given for fever, headache, or pain relief
ASA (Aspirin)	Yes ☐	No ☐	May be given for chest pain
Cortisone cream	Yes ☐	No ☐	May be given for an allergic reaction
Dimenhydrinate (Gravol)	Yes ☐	No ☐	May be given for motion sickness, nausea, or vomiting
Diphenhydramine (Benadryl)	Yes ☐	No ☐	May be given for an allergic reaction
Ibuprofen (Advil)	Yes ☐	No ☐	May be given for an anti-inflammatory or pain relief
Naproxen (Aleve)	Yes ☐	No ☐	May be given for menstrual cramps

Consent to Medical Treatment and Authorization to Release Information:

I, the undersigned, do hereby consent to any x-ray examination, anaesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instruction of the Pathfinder personnel, whether said diagnosis or treatment is rendered at the office of a physician or dentist, at a licensed hospital, or at the activity. It is understood that this consent is given in advance of any specific diagnosis or treatment, which might be required and is given to authorize Pathfinder leadership or the physician to exercise his/her best judgement as to the requirement of such diagnosis or treatment.

This consent shall remain in continuous effect until said minor is removed from the care of the Durham Trailblazers Pathfinder Club by the parent or guardian. The health information stated above is correct so far as I know.

Staff Name: _____ Date: _____

Print Name

_____

Signature