MEDICAL CONSENT FORM

PATHFINDER INFORMATION

First and Last Name:_____ ☐ **Female** ☐ **Male** **Date of Birth** (mm/dd/yyyy):_____

Street Address:_____ **Unit/Apt#:**_____

City:_____ **State:**_____ **Zip Code:**_____

Medical Insurance:_____ **Policy #:**_____

Policy Holder's Name:_____

Physician:_____ **Physician's Phone:**_____

PARENT/LEGAL GUARDIAN (PRIMARY CONTACT)

Full Name:_____ **Relationship to Member:** _____

Phone:_____ **Office/Alt Phone:** _____ **Email:**_____

Street Address:_____ **Unit/Apt#:**_____

City:_____ **State:**_____ **Zip Code:**_____

PARENT/LEGAL GUARDIAN

Full Name:_____ **Relationship to Member:** _____

Phone:_____ **Office/Alt Phone:** _____ **Email:**_____

Street Address:_____ **Unit/Apt#:**_____

City:_____ **State:**_____ **Zip Code:**_____

MEDICAL HISTORY

Height:_____ **Weight:**_____ **Current on Vaccinations:** ☐ Yes ☐ No ☐ Unknown Last Tetanus:_____

Food Allergies? ☐ No ☐ Yes Trigger/Reaction/Treatment:_____ Carries EpiPen? ☐ Yes ☐ No

Other/Environmental Allergies? ☐ No ☐ Yes Trigger/Reaction/Treatment:_____ Carries EpiPen? ☐ Yes ☐ No

Medication Allergies? ☐ No ☐ Yes Medicine:_____

Current Medications:_____

Any Activity Restricions:_____

Relevant Medical History (chronic illness, recent injuries or surgeries, diabetic, asthmatic, etc):_____

_____

EMERGENCY CONTACT TO NOTIFY IF PARENT(S)/LEGAL GUARDIAN(S) ARE UNAVAILABLE:

Full name:_____ **Relationship to Member:** _____ **Phone:**_____

In case of an emergency, I hereby give permission to the physician(s) and/or medical professional(s) selected by the club directors to render such treatment as deemed necessary, including to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child. I understand that every reasonable effort will be made to contact me. The information given by me on this form is correct to the best of my knowledge. This consent is effect from _____ **to** _____.

Parent/Guardian Signature: _____ **Date:**_____