Pathfinder Application & Health Record

Form must be filled out or reviewed, signed, and dated each year for the applicant to be an officially recognized Potomac Conference Pathfinder

Applicant's Demographic (Please Print)

Name: _____ Primary Contact Number: _____
(Last) (First) (Please list a number where we can reach you 24/7)

Address: _____ DOB: _____ E-Mail: _____

City: _____ State: _____ Zip Code: _____

School: _____ Phone: _____ Grade: _____

Parent/Guardian Demographic

Father/Guardian: _____ E-Mail:_____

Work Address: _____ Phone: _____

Mother/Guardian: _____ E-Mail: _____

Work Address: _____ Phone: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Pickup Authorization

Please list person(s) authorized to pick up your child from Pathfinder functions.

_____ _____ _____

Parents/Guardians your child will be released from Pathfinder functions only to persons listed above. If other arrangements are necessary, a note must accompany your child and a call must be made to the Club Director prior to the Pathfinder function. No exceptions! Thank you for your cooperation.

Parents/Guardians

We the Parent/Guardians of the above named Pathfinder applicant have read the Pathfinder Pledge, Law, rules and objective of this Pathfinder club and are desirous that the above named become a Pathfinder. We will assist the applicant with observance of the rules, maintaining and understanding the Pathfinder Pledge and Law, as well as assisting with the objectives of this Pathfinder Club. We also waive any and all claims against the Club Leadership, Pathfinder Club, Conference, Union, or North American Division of Seventh-day Adventist, for any accidents which may arise in connection with the activities of this Pathfinder Club, as permitted by law. I /we also understand my child may be photographed or video taped and I/we release all rights for their picture or video to be used for printed and web publications and advertising as permitted by law.

Parents/Guardians Signature: _____ Date: _____

Medical History and Information

The following information is critical for the safe care of your Pathfinder during routine Pathfinder activities and emergencies. Please answer all questions as to "yes" or "no" & if "yes" explain with additional information.

Y	N	
❑	❑	Does your child have any health history? (Asthma, Constipation, Epilepsy, Diabetes, etc)
❑	❑	Does your child have any difficulties that would effect them during Pathfinder activities?
❑	❑	Does your child have any allergies to medications? Please list with reaction.
❑	❑	Does your child have any allergies to foods, insects, or seasonal? Please list with reaction**.**
❑	❑	Are there any dietary considerations which should be considered when planning a menu?
❑	❑	Are there any physical restrictions that would effect your child during Pathfinder activities?
❑	❑	All Pathfinders are required to have up to date shot records, are there any shots that <u>are not</u>?
❑	❑	Is your child currently on any medications? If "yes" please list with dosage.

Insurance/Physician/Emergency Contact Information

Primary Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Medical Insurance: _____ Number: _____

(Please provide Pathfinder Club a copy of insurance card)

Being the Parents/Guardians of the applicant I/we certify the above medical history and information is correct to the best of our knowledge and the applicant has permission to engage in all Pathfinder activities except those noted. In the event the I/we cannot be reached in an emergency, permission is given to the adult leader to whom the applicant is charged to hospitalize, secure proper anesthesia or physician, order injection, surgery, resuscitation, or any care deemed necessary by that leader or physician to insure safe return of said applicant to his/her Parents/Guardians.

Parent/Guardian: _____ Date: _____

Form Review Signature

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____