



## PATHFINDER MEDICAL INFORMATION AND LIABILITY RELEASE RECORD

### Parent/Guardian and Emergency Contact Information:

In the following section, please list the parent's/legal guardian's name and contact information as well as an additional emergency contact person. The additional person will be notified if the parent(s)/guardian(s) cannot be reached.

Pathfinder's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mm/yy)  
 Parent(s)/Legal Guardian(s) \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ PC: \_\_\_\_\_ Daytime/Cell Phone:(\_\_\_\_) \_\_\_\_\_  
 Secondary Contact Person \_\_\_\_\_ Relationship to Pathfinder \_\_\_\_\_  
 Home Phone # (\_\_\_\_) \_\_\_\_\_ Daytime/Cell Phone # (\_\_\_\_) \_\_\_\_\_

### Pathfinder's Health Record and Medical Information:

The Ontario Conference of Seventh-day Adventists is required by law to obtain the following health information before accepting a Pathfinder participant. **Please include a copy of immunization record with registration form.**

Pathfinder's Physician \_\_\_\_\_ Office Phone # (\_\_\_\_) \_\_\_\_\_  
 Health Card # \_\_\_\_\_

**(Health card number MUST be included for admission to camp).**

#### **History:**

- |  |  |
|--|--|
| <input type="checkbox"/> Sore Throats    | <input type="checkbox"/> Sleepwalking  |
| <input type="checkbox"/> Sinusitis       | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Fainting        | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Stomach upset   | <input type="checkbox"/> Bed-wetting   |
| <input type="checkbox"/> Kidney problems |  |
| <input type="checkbox"/> Convulsions     |  |
| <input type="checkbox"/> Other _____     |  |

#### **Allergies:**

- |                                |  |                                  |
|--------------------------------|--|----------------------------------|
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Plants            | <input type="checkbox"/> Animals |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Bee/Insect Stings |                                  |

#### **Antidote:**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Benadryl           | <input type="checkbox"/> Anakit      |
| <input type="checkbox"/> Epikit             | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nurse administered |                                      |
| <input type="checkbox"/> Self care          |                                      |

Does the Pathfinder have an epi-  
pen? Yes  No

#### **Medications:**

**Is the child currently taking medication?**  No  Yes

Drug Name \_\_\_\_\_

Dosage \_\_\_\_\_

Time \_\_\_\_\_

#### **Permission to administer:**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Tylenol         | <input type="checkbox"/> Benadryl |
| <input type="checkbox"/> Aspirin         | <input type="checkbox"/> Naproxen |
| <input type="checkbox"/> Advil           | <input type="checkbox"/> Gravol   |
| <input type="checkbox"/> Cortisone cream |                                   |

### Medical and Liability Release:

I am/We are in favour of the aforementioned child attending Pathfinder events (i.e., fun days, fairs, rallies, field trips, club meetings, camporee, etc.) and participating in all activities. As parent(s)/legal guardian(s), I/We accept the conditions stated, including the release of the Ontario Conference of Seventh-day Adventists and the appointed health professionals from liability in case of accident or illness. I/We support, and the applicant agrees to abide by all event rules and Pathfinder regulations and polices. In case of emergency, I/we give permission to the nurse/adult leader selected by the Pathfinder Council/Club to hospitalize, secure proper treatment for, and to order injections, anaesthesia, or surgery for my/our child.

Parent(s) / Guardian \_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Print Name**

Parent(s) / Guardian \_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature**

Date: \_\_\_\_\_