

# HEALTH RECORD

(Please Print)

Child's Name:	
Allergies to medications? If yes, please list with reactions:	
Allergies to foods? If yes, please list with reactions:	
Are there any physical restrictions that would affect your child during Adventurer functions? If yes, please list:	
Tetanus Booster: <input type="checkbox"/> Y <input type="checkbox"/> N  Date: __/__/__	Is your child currently on any medications? If yes, please list with dosage.
Child's Physician:	Medical history (i.e., recent surgery, diabetic, chronic illness)
Phone #:	Insurance Company:
Address:	Policy #:

## AUTHORIZATION TO TREAT A MINOR

I, the undersigned parent, or legal guardian of:

\_\_\_\_\_ **Name of Adventurer**

give permission, in case of emergency, to the physician selected by the club directors to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child.

As parent or legal guardian of the applicant, I am in favor of him/her attending club functions and accept the conditions named. The health history stated is correct to the best of our knowledge, and the person herein described has permission to engage in all prescribed club activities except as noted. In addition, I have read and understand the Emergency Authorization statement and give my full consent to the terms found therein. Permission for photocopying of this health record is granted.

Date 08/ / 08 - 05/31/09 Parent/Guardian Signature \_\_\_\_\_