GULF STATES CONFERENCE
MEDICAL RECORD/CONSENT FORM

FULL NAME: _____
SOCIALSECURITYNUMBER:____-____-_____
ADDRESS:_____
CITY: _____ STATE: _____
ZIP: _____
HOME PHONE: (___)____-_____

FATHER'SNAME_____
FATHER'S CELL #
FATHER'S WORK PHONE: (___)____-_____
MOTHER'SNAME:_____
MOTHER'S WORK PHONE:(____)____-_____
LEGALGUARDIANNAME:_____
FAMILY PHYSICIAN: _____
PHONE (_____) _____-_____
MEDICAL INSURANCE COMPANY:
_____
INSURANCE POLICY NUMBER:
_____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING?

Heart disease	Immune Deficiency	Seizures/Convulsions
Asthma	Shortness of Breath	Emotional Disorders
High Blood Pressure	Cancer	Thyroid Problems
Kidney Disease	Liver Disease	Hyperactivity
Diabetes	Hepatitis	Bleeding/Hemophilia
Anemia	Heart Murmur	Back Problems

DOES YOUR CHILD HAVE ANY ALLERGIES? (i.e. food, medications, insect bites, hay fever, etc.)_____
_____
_____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? IF SO, WHEN? FOR WHAT? _____

IS THERE ANY REASON TO RESTRICT FULL ACTIVITY, INCLUDING, BUT NOT LIMITED TO SWIMMING, HIKING, OR STRENUOUS PHYSICAL ACTIVITY? _____

IF YES EXPLAIN_____

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS NOT COVERED ABOVE? _____

IS YOUR CHILD TAKING ANY MEDICATIONS AT PRESENT? YES/NO
IF YES, WHAT?

_____

_____

_____

I (We) are the parent, parents or legal guardian of

_____

(Name of Pathfinder)

In case of an emergency, I hereby give permission to the physician selected by the club directors 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, and the person herein described has permission to engage in all prescribed activities, except as noted by me.

Date: _____
Signed: _____
Relation to child:_____

NAD MEDICAL FORM