HEALTH RECORD

2021 PATHFINDER

Health Record

(This information will be kept confidential)

Name _____ Male / Female (circle one) Age _____ DOB_____

Height _____ Weight _____ Applicant's Blood Group (If known)_____

Medicare No._____Position_____ Other Health Care _____

Contact person in an emergency _____ Phone _____

Address of contact _____

Doctor's Name _____ Phone _____

If you answer "yes" to items 1-18, please supply full details on the lines below.

1. Heart Problems	yes	no	2. Respiratory Problems	yes	no
3. Travel Sickness	yes	no	4. Phobias	yes	no
5. Operations	yes	no	6. Recent Illnesses	yes	no
7. Migraines	yes	no	8. Blackouts	yes	no
9. Fits, Epilepsy, etc	yes	no	10. Asthmatic	yes	no
11. Diabetic	yes	no	12. Restrictions on Activities	yes	no
13 Bedwetting	yes	no	14. Special Diet	yes	no
15. Disability	yes	no	16. Medication Required	yes	no
17. Drug Reactions	yes	no	18. Allergies	yes	no
19. Can You Swim?	yes	no	20. Last Tetanus Booster – Date:		

DETAILS: _____

_____

_____

Authorisation and Agreement

In the event of accident or illness, I also authorise the Pathfinder Director to consent, where it is impractical or communicate with me, for me / my child to receive any x-ray examination, anaesthetic, medical, surgical or hospital treatment as may be deemed necessary by a licensed physician and/or surgeon. I also authorise to engage such treatment. I agree to pay the appropriate fees for such and any ambulance or other emergency transportation costs, which may be required.

I agree to meet the expense of me / my child being returned home, by the director or leaders. I understand that such an arrangement may be necessary due to illness, injury, or if, in the opinion of the Adventurer Director, non-cooperation of any description or the inability to meet the rigours and requirements of the activity.

I agree to me / my child attending the activity on this understanding.

Signed: _____ _____

Participant Date

Signed: _____ _____

Parent/Guardian (if applicant is aged under 18yrs) Date