Staff Demographic & Health Record

Demographic (Please Print)

Name: _____ Phone: _____
(Last) (First) (Middle)

Address: _____ Birthday: _____ E-Mail: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Cell Phone: _____ Pager: _____

Medical History and Information

The following information is critical for your save care during routine Pathfinder activities. Please make sure to answer every question as to "yes" or "no" and list any information that applies to the your care.

Y	N	
❑	❑	Do you have any health history? (Asthma, Ear Aches, Tuberculosis, Epilepsy, etc)
❑	❑	Do you currently have any physical limitations or other difficulties that may inhibit your abilities during any Pathfinder function? (Dyslexia, Phobias, Arthritis, Diabetes, etc)
❑	❑	Do you have any serious allergies to medications, foods, or other items? If "yes" please list and indicate type of reaction. (Peanut Butter, Bee Stings, Sea Food, Penicillin, etc)
❑	❑	Do you have dietary considerations which should be considered when planning a menu?
❑	❑	Do you have any physical restrictions that would effect you during any Pathfinder function?.

Insurance/Physician/ Emergency Contact Information

Primary Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Medical Insurance: _____ Number: _____

(Please provide club a copy of insurance card)

In the event that I am unable to grant permission for treatment, permission is given to the physician selected by the pathfinder leadership to hospitalize, secure proper anesthesia, order injection, surgery, resuscitation, or any care deemed necessary by that leadership or physician to insure safe return to normal quality of life.

Sign: _____ Date: _____

(Sign only in the presence of a Notary)