Continuing Consent to Treatment and Health Insurance Information

We, the undersigned parents or guardian of

_____ (Birthdate _____), a minor, do hereby consent
Name of Pathfinder

to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of _____, or any physician the
Name of Physician

organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called by the organization.

It is further understood that this consent is given in advance of any specific diagnosis or treatment, which might be required and is given to authorize _____
Pathfinder Club Organization

or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the organization entrusted with the custody of the said minor.

The above named member
Is
Is not
Covered by health insurance.
Present Health Insurance Company _____

Policy Number _____

_____ Date _____
Father

_____ Date _____
Mother

_____ Date _____
Legal Guardian

STATE OF ARIZONA	Subscribed and sworn to before me on this
County of _____	_____ day _____ 20 _____
	Notary Public _____
	Notary Expiration Date _____

The following information must be supplied for your son/daughter to join Pathfinders:

Check all that apply:

- ☐ Frequent Sore Throats
- ☐ Sinusitis
- ☐ Abscessed ears
- ☐ Bronchitis
- ☐ Fainting
- ☐ Stomach Upsets
- ☐ Constipation
- ☐ Bed Wetting
- ☐ Kidney trouble
- ☐ Convulsions
- ☐ Sleepwalking
- ☐ Athlete's foot

- ☐ Menstrual problems
- ☐ Heart trouble
- ☐ Headaches

Allergies:

- ☐ Drugs
- ☐ Foods
- ☐ Plants
- ☐ Bee Stings
- ☐ Other _____

_____

Continuing Physical Problems _____

_____

Current Immunization: Date: _____

☐ Tetanus ☐ Polio

☐ D. T Booster ☐ Measles

Activity Restrictions: _____

Suggestions _____

Person other than parent to contact in case of emergency: _____

_____ Phones: _____-_____-_____, _____-_____-_____

Please notify the Director if this child is exposed to any communicable disease.