Pathfinder Risk Management

CONFIDENTIAL

MEDICAL HEALTH INFORMATION FORM

PERSONAL INFORMATON:

FULL NAME: _____
LAST First M.I

ADDRESS: _____

_____
CITY STATE ZIP CODE

TELEPHONE: (_____) _____

CELL: (_____) _____

AGE: [ ] 10 [ ] 11 [ ] 12 [ ] 13 [ ] 14 [ ] 15 [ ] 16 [ ] 17 [ ] 18 or Older

MEDICAL HISTORY:

1. Has there been any change in your general health within the past year? [ ] Yes [ ] No
   If yes please indicate what: _____

2. Last Medical/Physical Examination was: _____

3. Are you currently under the ongoing care of Physician or medical provider? [ ] Yes [ ] No
   What are you being treated for: _____

4. Are you taking any prescribed or non- prescribed medications? [ ] Yes [ ] No
   If yes what are they: _____?
   How much do you take on a daily basis? _____
   Do you administer the medication yourself? [ ] Yes [ ] No

5. Do you have any of the following medical concerns?
   a. Heart problems [ ] Yes [ ] No
   b. Allergy [ ] Yes [ ] No to what? _____
   c. Sinus trouble [ ] Yes [ ] No
   d. Asthma [ ] Yes [ ] No

e. Hay Fever [ ] Yes [ ] No
f. Seizures/Fainting Spells [ ] Yes [ ] No
g. Diabetes [ ] Yes [ ] No
h. Hypertension [ ] Yes [ ] No
i. Anemia [ ] Yes [ ] No

6. Are you allergic or have had a bad reaction to:
   a. Local anesthetics [ ] yes [ ] No
   b. Penicillin or Antibiotics [ ] Yes [ ] No
   c. Sulfa Drugs [ ] Yes [ ] No
   d. Aspirin [ ] yes [ ] No
   e. Iodine [ ] Yes [ ] No
   f. Other [ ] Yes [ ] No Explain_____

7. If you are a women are you:
   a. Pregnant [ ] Yes [ ] No
   b. have menstrual problems [ ] yes [ ] No
   c. Nursing [ ] Yes [ ] No

I certify that I have read and understood the above and I acknowledge that in the event of a sudden illness or accident that the Officials of the Pathfinder Ministry are authorized by me or my guardians to release this information to Emergency Medical Service Personnel attending to my care.

Signature _____ Date: _____

Guardian: _____ Date: _____

MEDICAL PROVIDERS INFORMATION:

PCP NAME: _____

ADDRESS: _____

_____
CITY STATE ZIP CODE

TELEPHONE: (_____) _____

CELL: (_____) _____

PROVIDER TTYPE: [ ] Personal Physician [ ] HMO [ ] Clinic

INSURANCE INFORMATION:

Insurance Company: _____

Contact Number: _____

Name of Policy Holder: _____

Insurance Policy Number: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____

ADDRESS: _____

CITY_____STATE_____ZIP CODE_____

TELEPHONE: (_____) _____

CELL: (_____) _____

RELATIONSHIP: _____

PERMISSION TO TREAT:

In the event of sudden illness or accident requiring immediate attention, you are hereby granted permission to secure emergency medical services and use the information in this document for such purposes.

The above named person is a minor for whom I am the parent or legal guardian. As such you have my permission to obtain emergency medical services for same in the event of sudden illness or accident. Please not all medical conditions indicated specifically _____. During this trip I can be reached at the following telephone numbers for follow-up.

Home: (_____) _____ Work: (_____) _____ Other: (_____) _____

_____ _____

Printed name of Parent or Guardian Signature Date

SPECIAL INSTRUCTIONS:

_____

_____

_____

_____

_____