# Adventurer Health Record

Adventurer Name _____

Birth Date _____

Social Security Number _____

*Complete the Following:*

If yes to any of the following, please check and elaborate below or on back of form:

| | | |
|---|---|---|
| ____Frequent Sore Throats | ____Diabetic | ____Convulsions/Seizures |
| ____Frequent Ear Infections | ____Rheumatic Fever | ____Asthma/Lung Problems |
| ____Heart Defects/Disease | ____Stomach Problems | ____Bleeding/Clotting |
| ____Sickle Cell Disease/Threat | ____Kidney Problems | ____Sleepwalking |
| ____Mononucleosis | ____False/Capped Teeth | ____Bed-wetter |
| ____Glasses/Contacts | ____Sinusitis | ____Other_____ |

Allergies – Describe type of allergy and reactions and specify drug/medication names: _____

_____

Current Medications: _____

Date of last Tetanus Immunization/Booster: _____ Permission to Administer? ____Yes ____No

Approved over-the-counter medications: _____ Permission to Administer? ____Yes ____No

Physical Restrictions/Abnormalities – Describe: _____

Father's Name_____ Home Phone _____ Cell Phone _____

Work Phone_____ E-mail _____

Address_____ City_____ State_____ Zip_____

Mother's Name_____ Home Phone_____ Cell Phone_____

Work Phone _____ E-mail _____

Address_____ City_____ State_____ Zip_____

Emergency Contact Name & Phone (friend or relative) _____

Family Physician Name_____

Family Physician Address_____ City _____ State_____ Zip _____

Family Physician Phone(s)_____

Adventurer insurance coverage is to cover medical expenses up to a capped amount per person for injuries that occur to a Adventurer or Adventurer Staff Member while such a person is attending an approved Adventurer event or activity. Therefore, the above-named Adventurer's family health insurance is:

Insurance Company_____

Insurance Policy Number_____

(Please attach a photocopy of the front and back of your family insurance card.)

To make a claim for an injury sustained at a Adventurer event, use the blue form found in the Illinois Adventurer Directors Manual.

## Authorization to Treat a Minor

In the event emergency medical treatment becomes necessary for my child, we/I grant _____ (Adventurer club director) or his/her assistants authority to obtain such emergency medical assistance. We/I further grant permission for medical personnel to administer emergency medical treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the above-named director or to the club entrusted with the custody of said minor.

_____ _____

*Date* *Parent/Guardian Signature*