2017 Mid-America Union Pathfinder Camporee

Permission to Treat

Effective Dates: July 26 - 29, 2017

I hereby give permission to the medical personnel selected by the Pathfinder Director or his/her designee to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Pathfinder Director or his/her designee to secure and administer treatment, including hospitalization, for the person named below.

Permission to Administer Over-the-Counter Medications

I _____hereby give permission for

Parent

_____.

name of Pathfinder Club

to administer the following over-the-counter medications if the Pathfinder Director or his/her designee deems it necessary

to _____.

Name of person to receive treatment

Dosages will be administered according to directions by the manufacturer unless a physician directs otherwise.

- Headache Tylenol®
- Upset Stomach Pepto Bismol®
- Diarrhea Immodium AD®
- Menstrual Cramps Ibuprophen®
- Poison Ivy Calamine Lotion or CortAid®

Emergency contact Information:

(Print) Name:_____

Cell phone # _____ Home phone # _____

Work phone # _____

Signature _____ Date _____

Medical History

Check any and all that apply to your child: Date of Last Tetanus Booster_____

Illnesses

- ☐ Ear Infections
- ☐ Rheumatic Fever
- ☐ Convulsions
- ☐ Diabetes
- ☐ Other (specify) _____

Allergies

- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Ivy Poisonings
- ☐ Penicillin
- ☐ Other (specify) _____

Current prescribed medication(s). (Specify any special instructions for storage, handling or administration.)

_____

_____

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★All participants must be free of medical or physical conditions which might create undue risks to themselves or any others in the group who depend on them. Specify all health conditions, physical activity restrictions, or other health information. Also indicate if your child requires any special dietary needs. (Note: If you have had any heart-related problems, you will need to have a release form from a physician in order to participate in the activity or activities.)

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_____

Family Medical and Hospitalization Coverage

Name of Insurance Company or Government Program _____

_____

Identification/Policy # _____

Family Physician's Name _____

Phone Number _____