GULF STATES CONFERENCE

ADVENTURER CLUB

MEDICAL RECORD/CONSENT FORM

ADVENTURER FULL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ SS# _____

FATHER'S NAME: _____ MOBILE: _____

MOTHER'S NAME: _____ MOBILE: _____

LEGAL GUARDIAN NAME: _____PHONE: _____

FAMILY PHYSICIAN: _____ PHONE _____

MEDICAL INSURANCE COMPANY: _____

INSURANCE POLICY NUMBER: _____ PHONE: _____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING? Mark with an x bellow:

☐ Heart disease	☐ Immune Deficiency	☐ Seizures/Convulsions
☐ Asthma	☐ Shortness of Breath	☐ Emotional Disorders
☐ High Blood Pressure	☐ Cancer	☐ Thyroid Problems
☐ Kidney Disease	☐ Liver Disease	☐ Hyperactivity
☐ Diabetes	☐ Hepatitis	☐ Bleeding/Hemophilia
☐ Anemia	☐ Heart Murmur	☐ Back Problems

DOES YOUR CHILD HAVE ANY ALLERGIES? (I.e. food, medications, insect bites, hay fever, etc.)
If Yes, please list :

_____

_____

_____

_____

_____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? If Yes, when? List the hospitalizations:

_____

_____

IS THERE ANY REASON TO RESTRICT FULL ACTIVITY, INCLUDING, BUT NOT LIMITED TO SWIMMING, HIKING, OR STRENUOUS PHYSICAL ACTIVITY? ☐ YES ☐ NO

If Yes, why:_____

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS NOT COVERED ABOVE? Please list the reasons:

IS YOUR CHILD TAKING ANY MEDICATIONS AT PRESENT? ☐ YES ☐ NO

IF SO, WHAT? _____

I (We) the undersigned parent, parents or legal guardian of _____ ,
(Name of Adventurer)
in case of an emergency, I hereby give permission to the physician selected by the club directors to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child. I understand that every reasonable effort will be made to contact me.

The information given by me on this form is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed activities, except as noted by me.

Date: _____ Signed: _____

Relation to child: _____

NAD MEDICAL FORM

Gulf States Conference of Seventh-day Adventists®

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