ADVENTURER HEALTH RECORD

PLEASE ATTACH A COPY OF MINOR'S MOST RECENT PHYSICAL

ADVENTURER NAME:	
DATE OF BIRTH	LAST FOUR DIGITS OF SSN
DATE OF LAST TETANUS BOOSTER:	PHYSICAN NAME & PHONE NUMBER

ALLERGIES TO DRUGS/FOODS:
SPECIAL MEDICATIONS OR APPLICABLE INFORMATION:
LIST OF RESTRICTIONS:

FATHER'S CELL PHONE:	FATHER'S WORK PHONE:
MOTHER'S CELL PHONE:	MOTHER'S WORK PHONE:
EMERGENCY CONTACT NAME (FRIEND OR RELATIVE)	EMERGENCY CONTACT CELL PHONE NUMBER

PHYSICAN'S NAME:	PHONE NUMBER:
PHYSICAN'S ADDRESS:	CITY, STATE & ZIP CODE:
INSURANCE COMPANY:	POLICY NUMBER:

Authorization to Treat a Minor

I/We the undersigned parent(s) or legal guardian of _____, in case of emergency hereby give permission to the physician selected by the club directors to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child.

As parent or legal guardian, I am in favor of him/her attending club functions and accept the conditions named. The health history stated is correct so far as I know and the person herein described has permission to engage in all prescribed club activities except as noted. In addition, I have read and understand the Authorization to Treat A Minor statement and give my full consent to the terms found therein. Permission for photo copying of this health record is granted.

SIGNATURE OF PARENT AND/OR GUARDIAN	PRINTED NAME OF PARENT AND/OR GUARDIAN	DATE