MARANATHA PIONEERS PATHFINDER CLUB

SUPPLEMENT "B"

MEDICAL CONSENT TO TREAT

I (we) the undersigned parent(s) or legal guardian(s) of _____ (Born on _____), a minor, do hereby consent to any x-ray examination, injection, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of _____ (Phone# _____-_____-_____), or Name of Physician area code any physician the organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called by the organization unless necessary for life saving measures.

In addition consent is given for necessary life saving measures in rural conditions by qualified medical and Emergency Medical personnel appointed or call by the organization.

It is further understood that this consent is given in advance of any specific diagnosis or treatment, which might be required and is given to authorize _____ Organization or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in effect until revoked in writing and delivered to the organization entrusted with the custody of said minor.

The above named minor is □ is not □ covered by health insurance.

Insurance provider: _____Policy No. _____

Physician's office address:

_____

_____

As parent(s) legal guardian(s) of said minor I am in favor of him/her attending group functions and participating in group activities as scheduled, accept those prescribed restrictions found on page 3 of this form. The health history on page 3 of this form is correct to the best of my knowledge and I release from liability the organization, the staff and its leadership in case that this information may not be complete or correct and medical treatment is provided resulting in further injury or health risk.

In addition I have read and understand the above Emergency Authorization statement and give my full consent to the terms found therein. I consent to the photo copying or reproduction of this form and its use in confidential manner for the operation of the organization.

CONTINUING MEDICAL CONSENT TO TREAT—PAGE 2:

_____ _____

Father Date

_____ _____

Mother Date

_____ _____

Legal Guardian 1 Date

_____ _____

Legal Guardian 2 Date

STATE OF
COUNTY OF

Subscribed and sworn to, before me on this

_____

Day Month

Signature_____

My Notary Expires:

MEDICAL HISTORY FORM

The following information must be provided for your child to join the
Maranatha Pioneers Pathfinder Club

Check all that apply

□FREQUENT SORE THROATS
□ABSCESSED EARS
□SINUSITIS
□BRONCHITIS
□STOMACH UPSETS
□BED WETTING
□CONVULSIONS
□ATHLETE'S FOOT
□AUTISM/ASPERGER'S
□MENSTRUAL PROBLEMS
□HEART TROUBLE
□HEADACHES/MIGRAINES
□FAINTING
□CONSTIPATION
□KIDNEY TROUBLE
□SLEEPWALKING
□ADD/ADHD

□ALLERGIES:

DRUGS _____
FOODS_____
PLANTS_____
BEE STINGS_____
OTHER_____

_____
_____

Continuing Physical Problems:

_____
_____

Immunization record:

MMR DATE: _____ D.T.BOOSTER DATE: _____

TETANUS DATE:_____ POLIO DATE: _____

OTHER DATE:_____ OTHER DATE: _____

Activity Restrictions:

_____
_____
_____
_____

CONTINUING MEDICAL HISTORY FORM—PAGE 2

Personal contact information:

Father home phone_____ Father work phone_____
Mother home phone_____ Mother work phone_____
Father cellular phone _____ Mother cellular phone _____

Non-parent Emergency Contact:

Name:_____
Home Phone: _____Cell Phone: _____

Pathfinder's Name_____

OTC MEDICATIONS AND DETAILED HISTORY FORM

It is understood that there are many Over-the-counter medications today. We do not want youth carrying their own medications at any age, as minors we accept that they require supervision for the use of any drug or narcotic substance. This form offers you, the parent, the opportunity to inform us, the organization, as to what treatments you prefer your child to be administered for minor aches and pains as cared for by our first-aid team. The organization does not carry every conceivable OTC drug available, we will make our best endeavor to carry the most common for a variety of uses in name brand or generic form. If you list an item we do not carry the camp nurse will discuss the matter with you giving you an opportunity to provide the requested item or to choose and alternative item.

List the OTC drug you prefer for the items below please:

Headache _____
Migraine _____
Nausea _____
Cramping _____
Menstrual pain _____
Toothache _____
Muscle pain _____
Joint pain _____
Cuts and abrasions _____
Hay fever/antihistamine _____
Cold and flu _____
Other - list symptom and OTC drug: _____
_____

In case you or your minor's doctor cannot be reached please list any immunizations your minor has not received according to normal schedule. Please list any surgeries or internal procedures your minor has received and any metal pins or screws placed in bones etc. Also list any chronic diseases or heart, digestive, or pulmonary irregularities your minor suffers from. In the event of an emergency requiring a surgical procedure or MRI this will all be critical information and not having this information will delay medical action.

_____
_____
_____
_____
_____

Parent or Legal guardian signature Date

State Of
County Of
Signature/stamp

Subscribed and sworn to, before me on this
_____
day month year

OTC MEDICATION AUTHORIZATION

I, the parent/legal guardian of _____, give the Maranatha Pioneers Pathfinder staff permission to give the following non-prescription, over-the-counter medication to my son/daughter in the event that he/she displays the following symptoms without indication of a major underlying illness.

**** Our camp nurse will keep a supply of the most commonly administered OTC medications. Parents or guardians are welcome to provide a supply of their preferred medications to the camp nurse. ****

Please circle the medication(s) that we are authorized to give your child.

1. Headache of short duration and moderate severity:
   a. Tylenol b. Motrin c. None
2. Nausea, vomiting, diarrhea, gas pains:
   a. Emetrol b. Antacid c. Kaopectate d. Imodium A-d e. None
3. Cold, flu-like symptoms, including fever of short duration, sore throat, stuffy nose, cough, sinus congestion:
   a Tylenol b. Throat Lozenges c. Sudafed d. Robitussin DM e. None
4. Menstrual cramps of moderate severity:
   a. Tylenol b. Motrin c. None
5. Mild environmental allergic reactions
   a. Benadryl b. 0.5 Hydrocortisone Cream c. Caladryl Lotion
6. Stinging, burning, itching eyes caused by allergies or swimming:
   a. Visine b. None
7. Minor cuts and abrasions:
   a. Triple Antibiotic Ointment b. Hydrogen Peroxide c. None
8. Oher:_____

Parent/Legal guardian Signature: _____ Date:_____

State Of
County Of

Subscribed and sworn to, before me on this
_____
Day month year

Signature/stamp

Expiration

PRESCRIPTION MEDICATION AUTHORIZATION

I, the parent/legal guardian of _____, give Maranatha Pioneers Pathfinder Club staff permission to give the following Name of Organization prescription medication to my son/daughter according to the instructions I have provided in accordance with my minor's physician.

Please list the medication(s) that we are authorized to give your child. Please include dosage, intervals, and other pertinent information regarding the administering of the medications.

****All prescription medications must be supplied by parents or guardians in amounts that will last at least the duration of the event the minor is attending****

1._____

2._____

3._____

4._____

5. _____

6. _____

7. _____

Parent Signature **Date**

State Of
County Of

Subscribed and sworn to, before me on this
_____
Day month year

Signature/stamp

Expiration