

HOSPITAL CHURCH PATHFINDER MEMBERSHIP APPLICATION

Personal Information

Name: _____ Age ____ Birthdate _____

Address: _____ Male ___ Female ___

City, State: _____ Phone # () _____

Grade in School _____ Baptized? Yes ___ No ___ Name of Church: _____

APPLICANT'S COMMITMENT: I agree to be guided by the rules of the pathfinder club, and I will attend club meetings, campouts and other club outings and activities

Signature of Pathfinder

Date

Family History

Father: Seventh-day Adventist? Yes ___ No ___ Church: _____

Has he worked with Pathfinders before? Yes ___ No ___ Master Guide? Yes ___ No ___

Mother: Seventh-day Adventist? Yes ___ No ___ Church: _____

Has she worked with Pathfinders before? Yes ___ No ___ Master Guide? Yes ___ No ___

PARENT OR GUARDIAN APPROVAL: We hereby signify the applicant is in at least fifth grade. We are willing and desirous that the applicant becomes a Pathfinder. We will assist the applicant in observing the rules and guidelines of the Pathfinder organization. As parents (or guardians), we understand that the Pathfinder Club program is an active one for the applicant. It includes many opportunities for service, adventure, and fun. We will cooperate:

1. By learning how we can assist the applicant and his/her leaders.
2. By encouraging the applicant to take an active part in all club activities.
3. By attending events to which parents are invited.

Guardian Signature: _____ Date: _____

CLUB USE ONLY

___ Membership Application completed _____ Health & Medical Records

___ Dues Paid

Signature of Club Director: _____ Date: _____

MEDICAL CONSENT FORM

Child's Name _____ Birthdate _____ Sex _____

Social Security # _____ Phone _____

Address _____ City _____ State _____ Zip _____

Medical insurance _____ # _____

Father's Name _____ Home Phone _____

Social Security # _____ Office Phone _____ Mobile Phone _____

Address _____ City _____ State _____ Zip _____

Medical insurance _____ # _____

Mother's Name _____ Home Phone _____

Social Security # _____ Office Phone _____ Mobile Phone _____

Address _____ City _____ State _____ Zip _____

Medical insurance _____ # _____

Physician's Name _____ Phone _____

MEDICAL HISTORY

Weight _____ Height _____ Last Tetanus shot _____

Medication allergies _____

Medications receiving now _____

Medical history (i.e., recent surgery, diabetic, chronic illness) _____

Person to notify in case of accident or illness if parents are not available

Name _____ Phone _____

I, _____, (parent/guardian) give the following emergency medical treatment consent for the above named child. Effective from date of _____ to _____.

___ Emergency Surgery

___ First Aid

___ Both of the above

___ None of the above

(One of the types of treatment

must be marked.)

Signature of Parent/Guardian _____

Subscribed and acknowledged before me this _____ day of _____, _____ by _____, who is personally known to me or who has produced _____ as identification.

(Notarial Seal) Notary Public, State of Florida