Pathfinder Club Membership Application

I would like to join the _____Pathfinder Club. I will attend club meetings, hikes, camping and field trips, missionary adventures and other club activities. I agree to be guided by the rules of the club and the Pathfinder Pledge and Law.

Pathfinder Signature _____

Pathfinder Pledge

By the grace of God,
I will be pure, kind and true
I will keep the Pathfinder Law
I will be a servant of God
And a friend to man

Pathfinder Law

1. Keep the Morning Watch
2. Do my honest part
3. Care for my body
4. Keep a level eye
5. Be courteous and obedient
6. Walk softly in the sanctuary
7. Keep a song in my heart
8. Go on God's errands.

Annual Registration fee $50.00
Club Dues $10.00 per Month

Copy of Insurance Card must accompany this Application.

Name:_____ Phone: _____ AY Class:_____

Address: _____ City: _____ State: _____ Zip _____

E-mail Address_____ Date of Birth _____

Phone Number_____(home)_____(Cell)____

School:_____ Grade: _____ Church: _____

I have been a Pathfinder ❑ Yes ❑ No Where?_____
My dad is a Master Guide ❑ Yes ❑ No My dad has been a Pathfinder: ❑ Yes ❑ No
My mom is a Master Guide ❑ Yes ❑ No My mom has been a Pathfinder: ❑ Yes ❑ No

I wish to join the following **Special Club Program**: Drum Corps ❑ Color Guards ❑

Approval by Parents or Guardians

The applicant is at least 10 years of age or in 5th grade as a Junior Pathfinder, or in grade 7 as a Teen Pathfinder.

We have read the Pathfinder Pledge and Law and are willing and desirous that the applicant become a Pathfinder. We will assist the applicant in observing the rules of the Pathfinder organization. In consideration of the benefits derived from membership, we hereby voluntarily waive any claims against the club or the Southeastern Conference of Seventh-day Adventists for any accidents, which may arise in connection with the activities of the Pathfinder club.

As parents 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 activities.
3. by attending events to which parents are invited.
4. by assisting club leaders and by serving as leaders if called upon.
5. by purchasing Pathfinder insurance through the club treasurer.
6. by supplying needed information on the Membership Application and Health Record.

We hereby certify that _____ was born on _____
Applicant name *month/day/year*

_____ _____
Father's Name (Please Print) Father's occupation

_____
Father's Signature

_____ _____
Mother's Name (Please Print) Mother's occupation

_____
Mother's Signature

_____ _____
Guardian's Name Guardian's occupation

_____
Guardian's Signature

Date of application: _____

Subscribed and sworn before me this _____

day of _____, _____a Notary
Public in and for _____ County,

State of _____.

_____
(Signature)

NOTARY PUBLIC

My Commission expires _____, _____

OTC Medication Authorization

I, the parent/legal guardian of_____ , give the
Full Name of Youth
_____ staff permission to give the following
Name of Organization

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 medical staff 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 medical staff.***

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 e. None

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. Other: _____

Subscribed and sworn before me this_____

day of_____ ,_____ a Notary

Public in and for_____ County,

State of _____.

_____
(Signature)

NOTARY PUBLIC

My Commission expires_____ ,_____

Prescription Medication Authorization

I, the parent/legal guardian of_____ , give the
Full Name of Youth

_____ 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. _____

Subscribed and sworn before me this _____

day of _____ , _____ a Notary

Public in and for_____ County,

State of _____ .

_____

(Signature)

NOTARY PUBLIC

My Commission expires _____ , _____

Pathfinder Pick-Up Authorization

Pathfinder Name: _____ Parent/Guardian Name: _____

The following individuals are authorized to pick up my child from Pathfinder meetings and other Pathfinder functions.

Name: _____ Relation to Pathfinder: _____

Name: _____ Relation to Pathfinder: _____

Name: _____ Relation to Pathfinder: _____

Name: _____ Relation to Pathfinder: _____

All individuals must be at least 18 years of age, and be prepared to show a picture I.D. if he/she is not recognized by a staff member.

Any changes in this list must be made in advance, as your Pathfinder will not be released to anyone without prior written authorization.

This is for the safety of your Pathfinder, and your cooperation is appreciated.

All changes must be presented to the director by the parent/guardian in person.

_____ _____

Parent Signature Date Signed

_____ _____

Administrative Signature Date Signed

Pathfinder Club Photo/Video Waiver

I, _____ grant permission to _____ Pathfinder Club to take photos and videos of my child, _____ during any and all Pathfinder functions. I understand and agree that these photos and videos may be used in any manner that the Pathfinder staff deems appropriate. I further understand that any such use of the above mentioned materials would be done in a responsible and Christian manner and with the best interest of my child always in mind.

I also agree to relieve the _____ the church, and its staff of any legal responsibility for any issues arising from the use of my child's photos and videos.

_____ Pathfinder Name

_____ Parent/Guardian Name (Print)

_____ Witness Signature

_____ Parent/Guardian Signature

_____ Date

_____ Date

Pathfinder Club Website Waiver

I, _____ agree to allow the _____ to use photos and other general, non-invasive information (i.e. name, age, grade) pertaining to my child on the _____ Pathfinder Club Website.

I understand that any such use of the above-mentioned information and photos will be done in a responsible and Christian manner and with the best interest of my child always in mind. I also agree to relieve the _____ , the church, and its staff of any legal responsibility for any issues arising from the use of my child's information on the Pathfinder Club Website.

_____ _____

Name of Pathfinder Name of Parent/Guardian (Print)

_____ _____

Witness Signature Parent/Guardian Signature

_____ _____

Date Date

HEALTH AND MEDICAL RECORDS

(Every Individual Must Complete PAGE 1-2 and Bring a copy to every event)

Name _____ Age _____ Birth Date _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Male __ Female __

Pathfinder Club Name _____

Health History Have you had or currently have:

Past	Now		Past	Now		Past	Now		Past	Now	
☐	☐	Asthma ..	☐	☐	Earache/Ear Trouble	☐	☐	Glasses	☐	☐	Fever
☐	☐	Bed wetting	☐	☐	Ear Tubes	☐	☐	Hay Fever	☐	☐	Severe Stomachaches
☐	☐	Constipation	☐	☐	Epilepsy	☐	☐	Heart Trouble	☐	☐	Sinus Trouble
☐	☐	Contact Lenses	☐	☐	Fainting Spells	☐	☐	Kidney Disease	☐	☐	Sleep Walking
☐	☐	Diabetes	☐	☐	Frequent Diarrhea	☐	☐	Menstrual Problems (For Women Only)	☐	☐	Tuberculosis

Allergies or Allergic Reactions (Check if yes and tell what happened)

☐ **Medications**

_____

☐ **Bee Sting**

_____

☐ **Food**

_____

☐ **Poison Oak/Ivy**

_____

☐ **Other Allergies (list)**

_____

Please List All Serious Illnesses or Operations in the Past Five Years

Operation or illness	Date	Hospitalized (yes or no)
_____	_____	
_____	_____	

Please List All Medications Currently Being Taken

Medication	Date	Reason for Taking
_____	_____	_____
_____	_____	_____

Physical Activity

Any restriction of activity for medical reasons? Explain _____

_____

Any other types of health concerns, which might be pertinent? _____

_____

Any unusual behaviors (nightmares, sleep talking) _____

Immunization History

Required immunizations must be determined locally. This is a record of basic immunizations and most recent Boosters.

Check		Date	Check		Date
☐	Measles Vaccine (live)	_____	☐	Tetanus Booster	_____
☐	German Measles (Rubella)	_____	☐	Tuberculin Test	_____
☐	DPT Series	_____ Booster _____	☐	Chicken Pox	_____
☐	Polio OPV (Sabin)	_____ Booster _____	☐	Mumps Vaccine (live)	_____

Oregon Residents: Does your child meet current Oregon State law for school attendance? ☐ Medical Exemption ☐ Religious Exemption

Diet ☐ Regular ☐ Diabetic ☐ Low Salt ☐ Low Fat/Cholesterol ☐ Vegan ☐ Other _____

Inform in Case of Accident or Illness

Parent/Guardian/Spouse _____

Home Address _____Home Phone _____

Work Address _____Work Phone _____

If contact listed above is not available, in emergency notify:

Name_____ Name _____

Address _____ Address _____

_____ _____

Phone: Home _____ Work _____ Phone: Home _____ Work _____

Doctor to Consult in Case of Emergency

Name _____ Address_____

City _____ State _____ Zip _____Phone_____

Do You Have

Medical Insurance? _____ if yes, please provide Insurance Number _____
(Yes or No)

Insurance Name _____

PARENT'S AUTHORIZATION-required for those under 18 years of age or under 21 if still living at home.
This health history is correct so far as I know, and the child named above has permission to engage in all activities, except as noted herein by me. Exceptions (if any) _____. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injections or surgery for my child. A photo copy of this shall be as valid as the original.

Signature _____ Date _____
Parent or Guardian

TRAVEL & MEDICAL CONSENT FORM

(Every Individual Must Complete and Bring this form to Every Event)

Name _____ Age _____ Birth Date _____ ☐ M ☐ F
Address _____ Phone _____
City _____ State _____ Zip Code _____
Club _____ Grade in school _____
Parent / Legal Guardian(s) Name (Father) _____ (Mother) _____

Event Participation

I understand that I am required to give my consent before my child can participate in this event. By signing this form, I hereby represent that I am the custodial parent or legal guardian of the child listed below and that I consent to my child's participation in this event, including transportation to and from the event (if applicable).

Event: _____ Event Date: _____
Event Location: _____

Medical Permission

I give permission for adult leaders/volunteers to administer emergency treatment, contact emergency personnel, and act in my stead in approving necessary medical care until I can reasonably be contacted. I understand that should any medical bills be incurred, our family's insurance(s) may be used and the Southeastern Conference general liability insurance (Risk Management) is limited in amount up to a maximum of $5,000 for one year from the injury.

Family Insurance Company: _____

Family Insurance Policy Number: _____

Allergies: Please list all allergies your child has: _____

_____

Medications: Please list all medications your child takes: _____

_____

Physical Conditions: Please list any conditions that limit your child's participation in this event: _____

_____

Please list any **dietary requirements and/or allergies** that must be observed: _____

_____

I, on behalf of myself, my spouse, next of kin, executors, heirs, assigns, or anyone else who might claim or sue on my or my child's behalf, fully release and agree not to sue the Southeastern Conference of Seventh-day Adventists and any of its agents, employees, and/or volunteers from any and all liability, including but not limited to any claims, losses, or liabilities due to death, personal injury, disability, property damage, medical expenses, and/or theft, that may arise from or relate to my child's participation in the event, including transportation to and from the event and any provision of medical care.

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Parent/Guardian Name – please print) (Cell or Daytime Phone) (Nighttime Phone)