Pathfinders: Demographics & Medical Information

Student Name: _____ Date of Birth: _____ Gender: _____

Ethnicity: ☐ White ☐ African American ☐ Latino ☐ Asian ☐ Pacific Island ☐ Mixed Race Other: _____

Does your family meet the income eligibility guidelines for free or reduced lunch? ☐ **YES** or ☐ **NO**

(Please note, you may be asked to share one of the following forms of income verification: pay stub, federal income tax, eligibility for DSS, unemployment stub, child support payment stub. Thank you.)

Is it ok to leave your child home alone? **YES** or **NO**

If not, place to go if no one is home:

Name: _____ Relationship to the Student: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contacts (Other than Parents/Guardians in the event you cannot be reached)

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Home Phone: _____ Home Phone: _____

Cell/Work Phone: _____ Cell/Work Phone: _____

Other: Please list other relevant info that might be helpful for us to know about your child or family (cultural traditions, involvement with programs or services, etc.)

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Medical Information

Do you currently have OR do you have a history of the following:

Respiratory Problems? Asthma?	☐ YES ☐ NO
Allergies? (insects, food, medications)?	☐ YES ☐ NO
Neurological Problems?	☐ YES ☐ NO
Family history of cardiac disease?	☐ YES ☐ NO
Diabetes? (check one: _____ insulin _____ non-insulin dependent)	☐ YES ☐ NO
Seizures?	☐ YES ☐ NO
Dizziness or fainting spells?	☐ YES ☐ NO
Bleeding or Blood Disorders?	☐ YES ☐ NO
Past injuries/surgery/joint problems that could limit mobility?	☐ YES ☐ NO
Other diseases or recent illnesses?	☐ YES ☐ NO
Do you wear glasses?	☐ YES ☐ NO
Do you wear contact lenses? (if yes, hard or soft? _____)	☐ YES ☐ NO
Are you on any current medication(s)?	☐ YES ☐ NO
Are you prone to wetting the bed?	☐ YES ☐ NO
Can you swim? (deep end swimmer) Please explain below.	☐ YES ☐ NO
Can you ride a bike?	☐ YES ☐ NO
Special dietary needs? If yes please describe below.	☐ YES ☐ NO
Other (describe below)?	☐ YES ☐ NO

If you answered *yes* to any of the questions above please describe below. Also, please list **any other** medical condition that you think necessary for us to be aware of in case of an emergency.

_____

_____

Important Note: Due to NY state regulations, Outing Staff do not have license to administer medications, the exception is Ana or Epi devices. In certain cases, staff can administer medication if necessary (i.e. overnights, afternoon meds, etc.). Please see staff for appropriate forms and discussion.

Please fill out if *OVERNIGHTS* or *OUT of TOWN OUTINGS* are a part of your program:

Insurance Carrier: _____ Name of Insured: _____

Policy/ID #: _____ Group #: _____

Student's Primary Care Physician: _____

Address: _____

Phone Number: _____ Blood Type (if known): _____

Date of last Tetanus Booster (if known): _____ Up to Date on Immunizations (if known): ☐ YES ☐ No

Over Please