Pathfinder Club Membership Application

Name of Church Shiloh (Brooklyn) Year 2020-2021

Seventh-day Adventist Church of the Northeastern Conference

I would like to join the Shiloh Chrysolites **Pathfinder Club**. I will attend club meetings, campouts, missionary adventures, and other club outings and activities. I agree to be guided by the rules of the club and the Pathfinder Pledge and Law.

Name: _____ **Sex:** ___**Male** ___ **Female** **Email:** _____

Address: _____ **City:** _____ **ZIP Code**_____

Date of Birth: _____ **Age:** _____ **Phone:** _____

Registration Fee: $ 20/25 **Club Dues:** $ 5 monthly

Total Payment: $_____

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. Keep a level eye.
4. Be courteous and obedient.
5. Walk softly in the sanctuary.
6. Keep a song in my heart.
7. Go on God's errands.

Pathfinder Signature: :_____

Class: Friend Companion Explorer Ranger Voyager Guide

Applying for Membership _____ Renewing Membership_____ Transferring From Another Club_____

Name of club:_____**Location**_____

Approval by Parents or Guardians:

We hereby signify the applicant is at least 10 years of age. 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 claim against the club of the Northeastern Conference of Seventh-day Adventist 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 leaders
2. By encouraging the applicant to take an active part in all club activities
3. By attending events to which parents are invited.
4. By supplying needed information on the Membership Application and Health Record.

Signature of Father or Guardian_____ Date: _____

Signature of Mother _____ Date:_____

Date of Application: _____Pathfinder Name: _____

My Dad is a Master Guide __Yes __ no Other area of Youth Ministry_____
My Mother is a Master Guide __Yes __ no Other area of Youth Ministry_____
My Dad has been a Pathfinder __Yes __ no
My Mother has been Pathfinder __Yes __ no

Club Use Only

Check (√) box when completed.

Membership Application (this form) Health & Medical Record_____

Uniform Arrangements____ Pathfinder permission slip____

Date_____

_____Accepted into Preparatory Membership: Date: _____ Initial ___

_____Completed Preparatory Membership Date: _____ Initial: ___

_____Inducted into Full Membership Date: _____ Initial: ___

Name of Director: _____

Director's Signature:_____

Area Coordinator Signature_____ **Date:**_____

NORTHEASTERN CONFERENCE YOUTH MINISTRIES DEPARTMENT

PERMISSION TO PARTICIPATE IN ACTIVITIES/EVENTS/TRIPS

NECYM Ministries: Adventurer [Pathfinder] MG AYM Sports MCC Compassion Other —

Activity/Event Virtual Club Meeting Date: October 2020 to September 2021 Cost: —

Location of Activity/Event: Virtual Platforms of Zoom / Google

Time of Departure: TBA Time of Return: TBA Mode of Transportation: —

Leave From/Return to: — Activities: —

Leader Accompanying: Name: Pathfinder Staff Phone: _____

In case of emergency, the leader will notify the parent.

My child has permission to travel with the trip leaders and drivers selected and approved by my church board/conference, and sponsored by my local Seventh-day Adventist Church/Conference. I understand that my child will be chaperoned by either myself (if I am going), and/or adult leader and staff member while on this trip. I have already completed and given to the leader/director, my child's Health/Medical Information & Consent Form, which includes a signed consent to medical treatment.

My child _____ has permission to participate in Shiloh Virtual Club activities.

1. Child is in good health and can participate without any accommodations. Y or N

2. Child can participate with reasonable accommodations in respect to health or physical special needs.

List special needs: _____ Allergies: _____

3. During the activity or in case of an emergency, I may be reached at: _____

4. If I cannot be reached in the event of an emergency, the following person is authorized to act on my behalf for emergency medical treatment as is deemed necessary. I understand that this authority will be exercised only if reasonable attempts to contact me should fail. I authorize (adult): _____

Relationship to Participant: _____ Phone: _____

5. If I am driving children to, or during this event, I have completed and given to the club director my completed and signed Driver's Information Sheet, as well as my Youth Ministry Volunteer Form, (which is due whether or not I am a driver). In the event of an emergency, medical measures will be taken, and every attempt will be made to notify the parent/legal guardian bytelephone.

Notice to participant(s): Please be advised that you/your child may be photographed, videotaped, and /or recorded and the images may be made public for use in newspapers, newsletters, TV, radio, Internet. Such as, brief summaries of participation in events/activities for use in club/conference websites, marketing materials, presentations, and social media (including but not limited to: Facebook, YouTube, Twitter, Instagram, etc.)

Parent/Guardian Signature: _____ **Date:** _____

NOTE TO LEADER**: **This form along with completed Health/Medical form must accompany the responsible adult for this approved Event/Activity/Trip and copies given to the appropriate sources prior to event/trip/activity.** ****Parent please retain a copy*

Adventist Youth Ministries
Risk Management

CONFIDENTIAL

MEDICAL HEALTH INFORMATION FORM

NECYM Ministries: Adventurer (Pathfinder) MG AYM Sports MCC Compassion Other_____
Pick one level-----highest Rank

PERSONAL INFORMATON:

FULL NAME: _____
LAST First M.I

ADDRESS: _____

_____
CITY STATE ZIP CODE

TELEPHONE: (_____) _____

CELL: (_____) _____

AGE: _____

DOB: _____

MEDICAL HISTORY:

1. Has there been any change in your general health within the past year? [ ] Yes [ ] No
   If yes please indicate what: _____

2. Last Medical/Physical Examination was: _____

3. Are you currently under the ongoing care of a Physician or medical provider? [ ] Yes [ ] No
   What are you being treated for: _____

4. Are you taking any prescribed or non-prescribed medications? [ ] Yes [ ] No
   If yes what are they: _____?
   How much do you take on a daily basis? _____
   Do you administer the medication yourself? [ ] Yes [ ] No

5. Do you have any of the following medical concerns?
   a. Heart problems [ ] Yes [ ] No
   b. Allergy [ ] Yes [ ] No to what? _
   c. Sinus trouble [ ] Yes [ ] No
   d. Asthma [ ] Yes [ ] No
   e. Hay Fever [ ] Yes [ ] No
   f. Seizures/Fainting Spells [ ] Yes [ ] No
   g. Diabetes [ ] Yes [ ] No
   h. Hypertension [ ] Yes [ ] No
   i. Anemia [ ] Yes [ ] No

6. Are you allergic or have had a bad reaction to:

a. Local anesthetics	[ ] yes	[ ] No	
b. Penicillin or Antibiotics	[ ] Yes	[ ] No	
c. Sulfa Drugs	[ ] Yes	[ ] No	
d. Aspirin	[ ] yes	[ ] No	
e. Iodine	[ ] Yes	[ ] No	
f. Other	[ ] Yes	[ ] No	Explain_____

7. If you are a women are you:

a. Pregnant	[ ] Yes	[ ] No
b. have menstrual problems	[ ] yes	[ ] No
c. Nursing	[ ] Yes	[ ] No

I certify that I have read and understood the above and I acknowledge that in the event of a sudden illness or accident that the Officials of the Pathfinder Ministry are authorized by me or my guardians to release this information to Emergency Medical Service Personnel attending to my care.

Signature_____ Date:_____

Guardian:_____ Date: _____

MEDICAL PROVIDERS INFORMATION:

PCP NAME: _____

ADDRESS: _____

_____
CITY STATE ZIP CODE

TELEPHONE: (_____) _____

Cell (_____) _____

PROVIDER TTYPE: [ ]Personal Physician [ ] HMO []Clinic

INSURANCE INFORMATION:

Insurance Company: _____

Contact Number: _____

Name of Policy Holder: _____

Insurance Policy Number: _____

Revised: 1/12/2020

EMERGENCY CONTACT INFORMATION:

NAME: _____

ADDRESS: _____

CITY_____STATE_____ZIP CODE_____

TELEPHONE: (_____) _____

CELL: (_____) _____

RELATIONSHIP: _____

PERMISSION TO TREAT: MINOR

In the event of sudden illness or accident requiring immediate attention, you are hereby granted permission to secure emergency medical services and use the information in this document for such purposes.

The above named person is a minor for whom I am the parent or legal guardian. As such you have my permission to obtain emergency medical services for same in the event of sudden illness or accident. Please note all medical conditions indicated specifically_____. During this trip I can be reached at the following telephone numbers for follow-up.

Home: ( )_____Work: ( )_____Other: ( ) _____

_____ _____

Printed name of Parent or Guardian Signature Date

PERMISSION TO TREAT: Adult Staff/Volunteer–18 years off above

In the event of sudden illness or accident requiring immediate attention, you are hereby granted permission to secure emergency medical services and use the information in this document for such purposes.

I am the staff/volunteer listed above. As such you have my permission to obtain emergency medical Services for same in the event of sudden illness or accident. Please note all medical conditions indicated Specifically _____. During this trip I can be reached at the following telephone numbers for follow-up.

Home: ( )_____Work: ( )_____Other: ( )_____

_____ _____

Printed name – Adult Signature Date

SPECIAL INSTRUCTIONS:

Revised: 1/12/2020