



Girl Scouts of Western Washington Volunteer-Led Day Camp Registration

CAMPER'S NAME _____

Please indicate type of camper: Girl Scout K-12 Program Aide Adult Volunteer Boy (volunteer's son) Volunteer's preschooler

Name of Day/Twilight Camp _____
send registration form and payment to local camp registrar – address is with camp description on flyer or website

Parent/Guardian _____ Address _____

City _____ State _____ County _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Mobile Phone (____) _____

Email _____ This is her first year at this camp: yes no

Date of Birth _____ Age _____ School Grade (entering in Fall) _____

Buddy (optional – both girls must request each other) _____

T-shirt Size: My camper wears size: (circle one) **Youth:** S M L **Adult:** S M L XL XXL XXXL

Name of Person(s) other than Parent/Guardian to notify in case of emergency should we be unable to reach you:

Name _____ Phone _____ Relationship _____

Are there any special needs we should consider when placing your child in a camp unit? (e.g. severe allergies or other health or behavioral related concerns) _____

Please contact me about volunteering at camp!

GIRL SCOUT MEMBERSHIP:

Girl Scouts of Western Washington requires that all of our campers are currently registered members of Girl Scouts. If your camper is not currently a member of Girl Scouts, please visit www.GirlScoutsww.org to register prior to registering for camp. The cost is \$25 and covers membership through September 30, 2020.

Camper is currently a registered Girl Scout - Troop Number _____ Service Unit Number _____

Camper was recently registered with Girl Scouts. I am looking for a troop for my daughter: yes no

PAYMENT INFORMATION

Check or money order enclosed: Amount \$ _____

Cookie Rewards or credit card: Amount \$ _____ Card # _____

Financial Assistance – contact FinancialAssistance@girlscoutsww.org

FINANCIAL ASSISTANCE

Girl Scouts of Western Washington provides financial assistance as needed to support members to attend programs. All financial assistance applications must be received in our DuPont office **no later than 30 days before the first day of camp**. Questions about financial assistance should be directed to FinancialAssistance@girlscoutsww.org.

CONSENT OF PARENT/GUARDIAN

As parent/guardian having legal custody of the camper named above, who is voluntarily enrolled as a participant in the Girl Scouts of Western Washington Community Day/Twilight Camp program, I agree to instruct my child to observe rules and regulations governing the activities. I understand that camping programs involve inherent risk and possible injury because of the nature of the activity, even when conducted in a safe manner. I give permission for her to attend camp and participate in all phases of the program including off-site activities and related transportation.

I understand that her good health is required before she can attend camp. As the parent/guardian of the above child, I give permission for the above child to be photographed and/or audio/video taped during this event and for the images/recordings to be published, reproduced or distributed by Girl Scouts and its affiliates in all outlets, including but not limited to television, newspapers, internet, council publications, recruitment materials and ads without liability or limitation or claims on my or my minor's part. I have read the statements above. I understand the information and agree to allow my daughter/ward to participate in camp.

I give permission for my daughter/ward to join Girl Scouts, if she is not currently registered. I will go online to www.girlscoutsww.org and pay the \$25 membership fee and understand that membership fees are sent to GSUSA and cannot be refunded or transferred.

X _____ Date _____
Parent/Guardian Signature

Girl Scouts of Western Washington

Girl or Adult Health History Record

This health history is to be completed & signed by parent/ guardian of girls or by adult members for themselves.

Name () girl () adult: _____ Date of Birth: _____ Age: _____
Address: _____ Troop No. _____
Parent/Guardian: _____ Day phone () _____
Address: _____ Eve Phone () _____
Doctor's name: _____ Dr. Phone () _____
Emergency Contact: _____ Phone () _____

Part 1: Illnesses & injuries (check those that apply & give approximate dates)

Chronic or Recurring Illness:

- Ear infection, Musculoskeletal disorders, Bleeding/clotting disorders, Seizures, Hypertension, Diabetes, Asthma, Other, Heart defect/disease

Date of last health examination: _____ Is participant under a doctor/psychologist's care now? [] Yes [] No

Were any complicating medical problems noted in the last health exam? [] Yes [] No

Since last health exam, has participant had:

- A serious injury requiring medical attention? [] Yes [] No
Any prescribed or over the counter medications? [] Yes [] No
Treatment in a hospital or emergency room? [] Yes [] No
Any restrictions concerning physical activity? [] Yes [] No
An illness lasting more than five days? [] Yes [] No
A surgical procedure or fracture? [] Yes [] No
Any exposure to a contagious disease? [] Yes [] No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN, INCLUDING DATES:

Part 2: Allergies (Check those that apply & specify nature of allergic reaction)

- Animals, Hay fever, Pollen, Food, Meds/drugs, Insect stings, Plants, Other(specify)

Part 3: Other health conditions (Check those that apply)

- Bedwetting, Emotional disturbances, Constipation, Fainting, Menstrual cramps, Hearing impairment, Motion sickness, Sickle cell trait or disease, Nosebleeds, Special diet regime, Sleep disturbances, Wear glasses or contact lens, Other (Please specify)

Part 4: Immunization history:

Table with 3 columns: Immunization, Year primary series completed, Year of the last booster. Rows include D.P.T., Diptheria, Pertussis, Tetanus, Measles, Mumps, Rubella, Oral Polio, Tuberculin test.

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to ANY of these health conditions. Indicate any activities to be encouraged or restricted, and include any dietary restrictions.

For Parents: I know of no reason (s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian: _____ Date: _____

For adults: This health history is correct and I am able to participate in all prescribed activities except as noted.

Signature of adult: _____ Date: _____