

Adventurers **GIRL** Event/Program Registration

PLEASE MAIL OR EMAIL TO THE COORDINATOR IN CHARGE OF THE EVENT.

Event/Program:		Event Date:
Participant's Name:		
Age:	Grade:	Girl Scout Grade-Level:
Address:		
City:	State:	Zip:
Parent Phone #:	Parent Email:	
Height AND Weight (ONLY needed for backpacking, caving, kayaking, rock climbing & ziplining):		
How did you hear about this event?		

Are you registered as a Girl Scout (paid the annual membership fee for current year)?	
<input type="checkbox"/> Yes If yes, troop #:	
<input type="checkbox"/> No If no, please join Girl Scouts via the online membership sign-up: www.gsvsc.org/join and register with Adventurers Troop 1912 (zip code 24019).	

Additional information (for example: allergies, dietary restrictions, etc.) None

My daughter, _____, has my permission to participate in the Girl Scout Adventurers (name of event) _____

Photographs, videos, and audiotapes of my daughter may be used by Girl Scouts of Virginia Skyline Council for promotion and publicity. Yes No

During the activity, I can be reached at (phone number): _____ or _____.

Parent's Name:	
Parent's/Guardian's Signature:	Date:

MERCHANDISE

- Adventurers patch (\$2) Other event patch (\$2): _____ Adventurers Bandana (\$5)
- Cotton T-shirt (\$12): short-sleeve only; select size (Youth Large or Adult XL only) _____
- Sports Performance Shirt: short-sleeve (\$15) OR long-sleeve (\$20); select size (Adult Small-3X) _____

PAYMENT (PICK ONE METHOD TO COMPLETE)

- CHECK** enclosed for \$_____ made payable to "Adventurers-Girl Scout Troop 1912."
- CREDIT CARD** \$_____ (contact Laura Burchett: LauraBurchett90@gmail.com)
- VENMO** \$_____ (account name: @Adventurers-GSTroop1912)

COMPLETE HEALTH HISTORY NEXT

PARTICIPANT IS girl adult

ALLERGY ALERT (see Part 1 below) Yes No

GIRL/ADULT HEALTH HISTORY

Participant's First, Middle & Last Name:	
Date of Birth:	
Present Age:	
GS Troop #:	
Address:	
City, State, Zip:	

Primary Emergency Contact Name:	
Relationship to Participant:	
Phone # (include area code):	
Email:	

Alternate Emergency Contact:	
Relationship to Participant:	
Phone # (include area code):	
Email:	

Family Physician's Name:	
Phone # (include area code):	
Date of last health examination:	
Were any complicating medical problems noted in last health examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:	

Do you carry family medical/hospital insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Carrier:	
Policy ID#:	

Dentist/Orthodontist's Name:	
Phone # (include area code):	

Part 1: Allergies (check those that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> No known allergies | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Plants |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medicines/drugs | <input type="checkbox"/> Other (specify): |

List specifics of allergen(s) selected above and the type of reaction that occurs when exposed to allergen(s); e.g. food allergy to peanuts causes anaphylaxis:

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Part 2: Illnesses, Injuries, and Health Conditions (check those that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Musculoskeletal disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Bedwetting/sleep disturbances | <input type="checkbox"/> Heart defect/disease | <input type="checkbox"/> Sickle cell trait or disease |
| <input type="checkbox"/> Bleeding/clotting disorders | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Special dietary regimen |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Wears glasses/contact lenses |
- Other (specify):

Part 3: Other Health Information/Special Accommodations:

Are there any physical conditions for which special accommodations need to be arranged? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify:
Please specify details of special medical or dietary regimen to be followed:
Are there any psychological/emotional/behavioral situations that might arise (e.g., death in family, divorce, phobias, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify:
Additional information needed by adult leader about this participant:

Part 4: Immunization History

All immunizations are up-to-date (for minors)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> The participant is EXEMPT from immunizations. (Parent/guardian of exempt minors must complete the Girl Scout Medical Exemption Application – found on the last page.)	
Date of most recent tetanus shot (month/year):	

Part 5: Medication(s) (Prescribed, Over-the-counter, Vitamins)

Is the participant currently taking medication(s) (prescribed or over-the-counter) on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list medication(s) and reason for taking medication:
Will the participant be taking medication during the Girl Scout program? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, medication must be in the original container, with participant's name, and placed in a sealed plastic bag. Medications (with exception of epi-pens, inhalers, over-the-counter insect repellent, sunscreen) will be given to the adult in charge for the duration of the activity.</i>

Please check medications that may be given to the participant (medications available will vary by program):

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen (such as Tylenol) | <input type="checkbox"/> Sunblock (to be applied by girl) |
| <input type="checkbox"/> Antihistamine (such as Benadryl/Claritin/Zyrtec) | <input type="checkbox"/> Bug spray (may contain DEET) |
| <input type="checkbox"/> Simple antacid (such as Tums/Pepto-Bismol) | <input type="checkbox"/> Calamine lotion (for skin itching) |
| <input type="checkbox"/> Ibuprofen (such as Motrin/Advil/Midol) | <input type="checkbox"/> Decongestant (such as Sudafed) |
| <input type="checkbox"/> Hydrocortisone cream (for skin rash/itching) | <input type="checkbox"/> Anti-diarrhea (such as Imodium) |
| <input type="checkbox"/> Antibiotic ointment (such as Neosporin) | <input type="checkbox"/> Aspirin (adults only) |
| <input type="checkbox"/> Expectorant (such as Robitussin) | <input type="checkbox"/> Swimmers' Ear/alcohol-vinegar solution |
| <input type="checkbox"/> Motion Sickness (such as Dramamine) | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Topical pain reliever/anti-itch cream (such as After Bite) | |

Part 6: Signature (please select yes or no for each statement.)

- Yes No I am the parent/legal guardian of the minor named above and the minor is presently under my care, custody, and control (for minors only).
- Yes No The participant is physically fit and able to participate in the Girl Scout programs, including summer camp. To the best of my knowledge, the above information is complete and accurate.
- Yes No I give permission for the adult in charge to dispense medication as indicated in Part 5 above.
- Yes No N/A The participant has been trained in the use of: Auto-injector Inhaler and may carry their own device and self-administer as necessary. The participant is aware of the symptoms that necessitate its use, and will alert the adult in charge before, during, and/or immediately after using the device.
- Yes No Should an emergency arise, I will be notified immediately. If I cannot be reached, I direct that the alternate emergency contact be notified.
- Yes No Notwithstanding anything to the contrary herein, in the event of an emergency, GSVSC, its employees, agents and representatives and any third parties providing emergency medical services (including, but not limited to, emergency medical response personnel, doctors and hospitals, as applicable), are hereby authorized and directed to take such measures as they deem to be reasonably necessary and appropriate to provide appropriate medical care and treatment to the participant.

The following person(s) have permission to pick up the participant from troop meeting/program/camp. (**Photo ID required.**)

NAME	PHONE NUMBER	RELATIONSHIP

Signature of Parent/Guardian or Adult Participant:	
Date:	

GIRL SCOUT MEDICAL EXEMPTION APPLICATION

Complete ONLY if medical exemption is being requested (i.e. due to decision not to vaccinate)

Girl Scout's Name:	
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I do hereby certify that I am the parent/legal guardian of the Girl Scout named above (the "Girl Scout"). The Girl Scout is presently a minor. I hereby certify and acknowledge that said minor is presently under my care, custody, and control.

It is respectfully requested that the Girl Scout be exempted from all pre-activity physical examination, vaccination and/or immunization requirements in connection with Girl Scout activities. To the best of my knowledge and belief, she is and has been in normal good health and is free from all communicable diseases.

In consideration of these exemptions, it is understood that I accept complete responsibility for the health of this minor. I understand the risks associated with failing to receive such physical examinations, immunizations and/or vaccinations, but nevertheless request that the Girl Scout be exempted from these requirements.

It is further understood that should an emergency arise I will be notified immediately. If I cannot be reached, I direct that the alternate emergency contact be notified.

Notwithstanding anything to the contrary herein, in the event of an emergency, the Girl Scouts of Virginia Skyline Council, Inc., its employees, agents and representatives and any third parties providing emergency medical services (including, but not limited to, emergency medical response personnel, doctors and hospitals, as applicable), are hereby authorized and directed to take such temporary measures as they deem to be reasonably necessary and appropriate to provide appropriate medical care and treatment to the Girl Scout

Signature of Parent/Guardian or Adult Participant:	
Date:	
Street Address:	
City:	
State & Zip Code:	
Day Phone #:	
Evening Phone #:	
Email:	