Adventurers ADULT Event/Program Registration

PLEASE MAIL A COPY OR EMAIL A PDF TO THE COORDINATOR IN CHARGE OF THE EVENT (NO IMAGE FILES)

Event/Program Name:		Event Date:
Participant's Name:		Age:
Address:		
City:	State:	Zip:
Phone #:	Email (USED WITH GIRL SCOUTS):	
How did you hear about this event?		

Are you registered as a Girl Scout (paid the annual membership fee for current year)?	
☐ Yes If yes, troop #:	
☐ 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 [allergies; food preferences & restrictions (vegetarian, vegan, allergies); mental health concerns; etc.]

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

Name:	
Signature:	Date:

PAYMENT (PICK ONE METHOD YOU WILL PAY PROGRAM COST AND/OR MERCHANDISE COST)

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

MERCHANDISE

☐ Adventurers patch ($2)
☐ Adventurers bandana ($5)
☐ Sports Performance Shirt: short-sleeve ($15) OR long-sleeve ($20) in Adult Small-3X; select style & size _____
☐ Adventurers 2-inch decal ($1)
☐ Adventurers 4-inch decal ($3)

COMPLETE HEALTH HISTORY—NEXT PAGE

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? ☐ Yes ☐ No	
If yes, please explain:	

Do you carry family medical/hospital insurance: ☐ Yes ☐ No	
Carrier:	
Policy ID#:	

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

Part 1: Allergies (check those that apply):

☐ No known allergies ☐ Hay fever ☐ Plants
☐ Animals ☐ Insect Stings ☐ Pollen
☐ Food ☐ Medicines/drugs

☐ 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:

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

☐ ADHD/ADD	☐ Ear infection	☐ Musculoskeletal disorders
☐ Arthritis	☐ Fainting spells	☐ Nosebleeds
☐ Asthma	☐ Hearing impairment	☐ Seizures/convulsions
☐ Bedwetting/sleep disturbances	☐ Heart defect/disease	☐ Sickle cell trait or disease
☐ Bleeding/clotting disorders	☐ Hypertension	☐ Sleep Apnea
☐ Constipation	☐ Kidney disease	☐ Sinusitis
☐ Diabetes	☐ Menstrual cramps	☐ Special dietary regimen
☐ Eating disorders	☐ Motion sickness	☐ 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? ☐ Yes ☐ 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.)? ☐ Yes ☐ 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)? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No
If yes, please list medication(s) and reason for taking medication:
Will the participant be taking medication during the Girl Scout program? ☐ Yes ☐ No
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 repellant, sunscreen) will be given to the adult in charge for the duration of the activity.

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

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

_____

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

☐	Yes	☐	No	☐	N/A	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 (girl)/I am (adult) physically fit and able to participate in this Girl Scout program. 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, contact the primary emergency contact immediately. If the primary contact 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:	