



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: (Check 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, a \$25 membership fee is required with registration.

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

Camper is not currently a registered Girl Scout – include an additional \$25.00 to cover membership through September 30, 2018

PAYMENT INFORMATION

Check or money order enclosed: Amount \$ _____

Cookie Rewards: Amount \$ _____ Cookie Rewards 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 have included my \$25 membership fee with this registration and understand that membership fees are sent to GSUSA and cannot be refunded or transferred.

X _____ Date _____
Parent/Guardian Signature

Remember to complete and sign both sides of this form!

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 () _____

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

Chronic or Recurring Illness:

Ear infection Bleeding/clotting disorders Hypertension Asthma Heart defect/disease

Musculoskeletal disorders Seizures Diabetes Other _____

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 An illness lasting more than five days? Yes No

Any prescribed or over the counter medications? Yes No A surgical procedure or fracture? Yes No

Treatment in a hospital or emergency room? Yes No Any exposure to a contagious disease? Yes No

Any restrictions concerning physical activity? 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:

Immunization	Year primary series completed	Year of the last booster
D.P.T.	_____	_____
Diphtheria	_____	_____
Pertussis (whooping cough)	_____	_____
Tetanus	_____	_____
Tetanus/Dip booster	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
(German Measles)	_____	_____
Oral Polio	_____	_____
Tuberculin test (most recent)	_____	_____
Other:	_____	

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:** _____