

Camp, Travel, & High-Risk Event Participation Form

Personal Information

Participant's Full Name

Date of Birth:

Address:

Participant Lives With:

One Parent Two Parents Guardian Other:

Name of Parent/Guardian:

Parent/ Guardian Email:

Parent/ Guardian Phone:

Does this person have permission to pick up Participant?

Yes No

Name of Parent/Guardian:

Parent/ Guardian Email:

Parent/ Guardian Phone:

Does this person have permission to pick up participant?

Yes No

Who would you like listed as the emergency contact? Please list full name and phone number.

[Redacted]

Are there any custody situations of which we need to be aware?

[Redacted]

Who would you like listed as the emergency contact? Please list full name and phone number.

[Redacted]

Does Girl Scouts of the Sierra Nevada have permission to transport camper? This would only be in cases of field trips off main campus (to a pool or additional venue) or in the case of an emergency. All staff driving youth are trained to drive the Girl Scout van, have clean driving records, and will be with an additional chaperone.

Yes No

Additional Adults Permitted to Pick Up (Optional)

Please list name, relationship and phone numbers for any additional persons who MAY pick up the camper.
We cannot release minors to any individuals not noted on this form.

Name

[Redacted]

Relationship

[Redacted]

Phone:

[Redacted]

Name

[Redacted]

Relationship

[Redacted]

Phone:

[Redacted]

Name

[Redacted]

Relationship

[Redacted]

Phone:

[Redacted]

Name

[Redacted]

Relationship

[Redacted]

Phone:

[Redacted]

Insurance Information

Is the participant covered by insurance?

Yes

No

Family Medical/ Hospital Insurance Carrier

Policy or Group Number

Name of Family Physician

Phone Number of Family Physician

Family Dental Insurance Carrier

Policy or Group Number

Permission for Emergency Treatment*

In the event the participant becomes ill or sustains an injury while in the care of or under the supervision of the Girl Scouts of the Sierra Nevada or any of its officers or leaders, I authorize first aid to be administered. If it should become necessary to seek professional medical treatment, I give permission for a licensed medical professional to administer any medical and/or surgical treatment he/she deems necessary, including hospitalization. I understand that every effort will be made to contact me, or if not possible, an Emergency Contact. I accept full financial responsibility for all expenses incurred that are not covered by Girl Scout Activity Insurance.

I DO NOT desire this authorization and understand that in so choosing I release and relieve from all liability whatsoever Girl Scouts of the Sierra Nevada, its officers and leaders.

If declining permission for emergency treatment, please describe alternative procedure:

Health History

Date of last health examination

Since the last health examination, has the camper had:
A serious injury requiring medical attention?

Yes No

Treatment in a hospital or emergency room?

Yes No

Any exposure to a contagious disease?

Yes No

An illness lasting longer than 5 days?

Yes No

Restrictions from participating in any activities?

Yes No

Surgery?

Yes No

Please give explanation for any selected "yes" above.

Are all immunizations current?

Yes No

If no, please state reason

Date of last tetanus shot:

Does the participant have any chronic and/or recurring illness? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> MuscleDisease/ Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> NervousSystem Disorder |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> SkeletalDisease/ Disorder |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> UrinaryTract Infection |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> None of the above |

Other: Please explain

Does the participant experience any of the following conditions? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Stomach Upsets |
| <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Wears Contacts or Glasses |

Other: Please explain

Is the participant restricted or limited from participating in any physical activity? If yes, please describe

- Yes No

Does the participant have any known allergies? (Check all that apply)

- Animal Fur/ Dander
- Bee/ Insect stings
- Pollen/ Plants
- Foods
- Drugs
- Other
- None of the above

If you checked an allergy box above please describe the reaction and actions taken.

Does the participant have any dietary restrictions?

- Allergy (listed above)
- Dairy Free
- Gluten Free
- Nut Free
- Vegan
- Vegetarian
- Other
- None of the above

If other, please describe

My participant uses an inhaler

Yes
 No

If yes, should the inhaler be kept on the participant, with their troop leader, or with GSSN staff?

Mental Health History

Does your participant experience any of the following conditions?
(Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Lack of impulse control |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Learning Disorder |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Self Harm |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Other |
| <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> None of the above |

Other: Please list

If any above boxes were checked, do you have any strategies at home that we can use to support your participant?

Is your participant feeling nervous about any of the follow aspects of this experience?

- Being around new people
- Sleeping away from home
- Being outdoors
- Wildlife
- Not using electronics
- Camp meals/new foods
- Other
- None of the above

Is there anything else that we should be aware of?



Over-the-Counter(OTC)Form

First Aider should customize their First Aid Kit to fit the group.

Child's name: _____ AGE _____ WEIGHT _____

Child ALLERGIES: _____ TROOP# _____

Please help us keep your child safe by informing us of what you do not want your daughter to be given and include unmentioned medicines we should avoid.

*All medication must be in its original container with a readable label and clear expiration date.

MEDICINE NOT to be used (if not listed below): _____				
<i>Medication</i>	<i>Dosage according to the MRSD* label</i>	<i>Usage</i>	<i>Can be used?</i>	
Acetaminophen, Tylenol Reg. & Extra Strength	Reg. 250mg ES 500mg	minor aches, pains, cramps, fever indigestion, gas	YES	NO
Antacid, Pepto-Bismol, Tums	According to label	Motion sickness	YES	NO
Dramamine/Bonine	According to label	Low blood sugar	YES	NO
Ibuprofen, Advil, Motrin (non-aspirin)	According to label	Minor aches, pains, fever	YES	NO
Naproxen, Midol, Pamprin, Aleve	1 or 2 tabs, 200mg	Minor aches, pains, fever	YES	NO
Throat lozenges/ cough drops	1 or 2 tabs, various	Sore throat	YES	NO
Antihistamine, Benadryl topical & oral, Caladryl/Calamine lotion, Sting/Bite wipes, Hydrocortisone, Burn gel	According to label According to label	stings, bites, colds, allergies, itch relief burn relief	YES YES	NO NO
Eye wash, contact lens solution		Irritation of the eye	YES	NO
Hand Sanitizer		hand sanitation	YES	NO
Petroleum jelly		dry skin, dry nose	YES	NO
Neosporin foam, wound cleaner, BZK wipes, hydrogen peroxide		wound cleaning treatment	YES	NO
Insect Repellent	Small dab to area	insect repellent	YES	NO
Sunscreen, Aloe Vera gel	NON DEET	Sun protection, sun burn wound care	YES	NO
Triple antibiotic/ Polysporin/Neosporin	According to label, can be carried as age appropriate		YES	NO
Other:			YES	NO

* Manufacturer's Recommended Starting Dosage

I give permission for my daughter (named above) to receive products listed on an as needed basis. I understand that our troop/service unit isn't expected to carry all the following items in their First Aid kit _____ (Initials).

To the best of my knowledge she is not allergic to any of the items she has been authorized to use. Unless otherwise directed, the medications will be administered as directed by package labeling.

When going on Overnight trips with a group, your child may bring their own OTC medications from home. You must provide written permission to the firstaider, for any medications you may send with your child.

Parent Signature _____ **Date** _____

Parent Print Name: _____ Phone Number: _____

Provided Prescription and/or Provided OTC Medication Form

Child's name: _____ Troop #: _____

Parent/caregiver: Please complete, sign, and submit this form to the troop leader/first aider for each trip your child takes or when changes occur. This is required for the adult to assist with any prescription or administer over-the-counter medication **you provide** to the troop/group.

All medications **must** be kept in the possession of the adult first aider, the **only** exceptions are: Prescribed rescue or emergency medications can be carried by user unless they are unable to self-administer.

All medication; prescription and parent/caregiver provided, must be in its original container with original label, dose and expiration date. Prescription labels must include child's name, physician's name and phone number. These **must** be handed over in a clear resealable bag identified with the child's name on it.

My child takes the following medication(s) on a DAILY basis and will need them with her while in your care: Please indicate those also carried by the child.			
Medication Name	Dose	Frequency	Time Administered/Taken
Special instructions:			

Medications I have already given my child today:			
Medication Name	Dose	Frequency	Time Administered/Taken

My child is currently taking the following medication/s on a temporary basis and will need to use them while in your care: This area is for antibiotics and/or any medication the parent/caregiver deems allowable to the child.			
Medication Name	Dose	Frequency	Time Administered/Taken
Special instructions:			

Parent/caregiver signature: _____ Date: _____

The participant uses an EpiPen Yes No

If yes, should the EpiPen be kept on the participant, with their troop leader or GSSN staff?
(It's recommended that participants bring 2 EpiPens if they are know to need them for multi-day trips.)

Participant Behavior Contract and Parent/Guardian Release of Liability

I consent for photos to be taken and used in social media and publicity for GSSN

Yes No

I authorize that all sections of this registration packet have been answered truthfully and to the best of my knowledge.

Signature

Please have participant read (or read to participant) and sign the following statement: "I understand that while I am at a Girl Scout activity, including Travel, Camp, or other Activity I will live by the Girl Scout Law. I will do my best to be Honest and fair (I will take turns and only pack what is necessary), friendly and helpful (I will do my kapers), considerate and caring (I will be kind to others), courageous and strong (I will challenge myself), and responsible for myself and others (I will use appropriate language and have appropriate conversations), respect myself and others (I will respect others space and belongings), respect authority (I will listen to leaders and staff) use resources wisely (I will stay hydrated and be water wise), make the world a better place (I will keep our environment clean and free of trash), and be a sister to every Girl Scout (I'll be inclusive to everyone in our group)."

Signature

This agreement is given in consideration of my child's voluntary participation in the above-named camp, travel event or activity hosted and operated by the Girl Scouts of the Sierra Nevada, or by Girl Scout Troop Volunteers hereinto referred to as "the Event"). **INFORMED CONSENT WARNING AND ASSUMPTION OF RISK** I understand that there are inherent risks and dangers associated with participation in the Event. I assume responsibility and confirm that my child is in adequate physical condition and physically able to participate in activities such as, but not limited to: walking, playing games, sports, swimming, overnight stay, generally touring and accessing outdoor facilities and activities. I understand that participation in the Event may involve risks including but not limited to: physical injury, drowning, permanent injury, disabilities and even death. I agree to assume all risks, whether known or unknown to me, of my child participating in the Event. **RELEASE OF LIABILITY** On behalf of myself and my heirs, I hereby waive, release and discharge any and all claims of damages for death, bodily injury, personal injury or property damage which my child may sustain, or which hereafter accrue to my child, against the Girl Scouts of the Sierra Nevada, its volunteers and/or staff (hereinafter "the Council") as a result of my child's participation in the Event except for those liabilities, claims and costs arising from the sole active negligence of the above. This release is intended to indemnify and hold harmless the Council from and against any and all liability arising out of or connected in any way with my child's participation in physical activities except for the related sole active negligence of the Council. It is further understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs and assigns. **MEDICAL CONSENT** If medical attention, beyond first-aid treatment, is required, I understand that an attempt will be made to contact me at the phone number I provide below. If contact with me is not made, I give permission for medical attention to be administered and my medical insurance to be contacted, as shown below. **ACKNOWLEDGEMENT AND AGREEMENT** I acknowledge that I have been fully informed of the risks and dangers involved in the Event. I acknowledge that I have read, agree, and fully understand the above Warning, Assumption of Risk, Release of Liability, Waiver and Medical Consent. I understand that I am giving up important legal rights, including the right to sue. I am the Parent/Guardian of the below-mentioned participant who is a minor child (under 18 Years old). By signing as Parent and Guardian, I agree on behalf of the Participant, to the entirety of the statements above.

Signature
& Date