



Adult Registration – Short Term Resident Camp

Girl Scouts Heart of Central California | 3621 Forest Glenn Dr, Modesto, CA 95355 | www.girlscoutshcc.org

Please mail a complete registration packet to the Camp registrar. Packet to include for Adults:

- One completed adult registration form (attach one Girl Registration form for each daughter attending)
- Payment by check
- Business Size, Self-Addressed Stamped Envelope

Name of Camp _____ Camp Dates _____

Name of Adult _____ Camp Nickname Name _____

Daughter's First & Last Name (if attending) _____ Grade in School (fall) _____

2ND Daughter's First & Last Name (if attending) _____ Grade in School (fall) _____

Day Phone (____) _____ Eve. Phone (____) _____

Cell Phone (____) _____ Email _____

Mailing Address _____ City _____ Zip _____

Person to contact in case of emergency: _____ Phone (____) _____

Camp staff position preferred: Unit Leader _____ D _____ B _____ J _____ C _____ Shopper _____

Overnight Patrol _____ Other: _____

- Have you had a reference check done by Girl Scouts Heart of Central California? No Yes
(If yes, what position? _____)
- **If no, complete the enclosed *Girl Scout Volunteer Position Application* and return with this registration. Background checks are required for all adults.**
- Are you currently registered with Girl Scouts? No Yes
- **If no, please include adult GSUSA membership form and \$12 membership fee.**
- Have you ever attended a Girl Scout camp? No Yes When: _____
- Have you ever worked at a Girl Scout camp? No Yes When: _____
- Have you completed Girl Scout camp training? No Yes When: _____
- Do you have current first aid/CPR certification? No Yes When: First Aid _____ CPR _ _____
- Are you troop camp certified by this council? No Yes When: _____
- Are you a current volunteer leader? No Yes Troop # _____
- Other certifications (lifeguard, archery, canoe, child care, etc.) No Yes
- Do you speak a language other than English? No Yes What language? _____
- Check your T-shirt size (Adult Sizes): S (34-36) M (38-40) L (42-44) 1X 2X 3X

I understand that to be appointed for a volunteer position at this camp, I must have the GS Volunteer Position Application completed and on file, attend required trainings, and plan on committing to the full length of the short term resident camp.

Signature: _____ Date _____

Comments/Questions: _____



Adult Emergency Health Information

Girl Scouts Heart of Central California | 6601 Elvas Avenue Sacramento, CA 95819 | www.girlscoutshcc.org

Name _____ Birthdate _____ Troop # _____

Address _____ City _____ Zip _____ Home phone (_____) _____

Family medical/hospital insurance carrier _____ Policy or Group No. _____

Emergency Contacts (in the event participant cannot be reached)

Name _____ Name _____

Relationship _____ Relationship _____

Day Phone (_____) _____ Day Phone (_____) _____

Evening Phone (_____) _____ Evening Phone (_____) _____

Cell Phone (_____) _____ Cell Phone (_____) _____

Email _____ Email _____

Do you have any allergies, special needs or a special diet we should be aware of? Yes No

If Yes, please explain: _____

(For example, please list all medications, plants, animals, etc. that you are allergic to and/or indicate whether you have special needs like asthma or diabetes.)

Please provide any information in relation to your care that would be useful to the person in charge. Also indicate any activities to be encouraged or restricted. _____

The above information is correct to the best of my knowledge. I hereby authorize Girl Scouts Heart of Central California, to order emergency X-rays, anesthetic, medical or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician. It is understood that every reasonable effort will be made to contact the person noted above before taking this action. I understand that this permission is given in advance of need for any diagnosis, treatment, or hospitalization. This authorization shall remain effective throughout the entirety of the individual's membership in the Girl Scouts Heart of Central California.

I agree to inform a troop or activity leader of any changes in the above information.

Date

Signature of adult

Updated

Signature of adult

Updated

Signature of adult

All Girl Scouts registered in the USA are insured by:
MUTUAL OF OMAHA INSURANCE COMPANY
Girl Scout Division, Group Policy #SGS-2-8012 6-3632
Dodge at 33rd Street
Omaha, Nebraska 68175

Girl Scouts Heart of Central California
6601 Elvas Ave
Sacramento, CA 95819
(916) 452-9181 or (800) 322-4475

MAIL
No later than 4 weeks prior to camp session.

Girl Scouts Heart of Central California
**CAMPER HEALTH HISTORY
 AND EXAM RECORD**

Camp Name (Circle One)
 Golden Timbers / Yosemite Camp of Service

Camper's Name _____ Birthdate _____
 Address _____ Phone (____) _____
 number street city state zip

Parents/Guardians:

(1) Name _____ Home Phone (____) _____
 Place of work _____ Title _____ Work Phone (____) _____

(2) Name _____ Home Phone (____) _____
 Place of work _____ Title _____ Work Phone (____) _____

If parents can't be reached, call (Name) _____ Phone (____) _____
 Address _____ Relationship _____
 Name of Family Physician _____ Phone (____) _____
 Name of Dentist/Orthodontist _____ Phone (____) _____
 Family Medical/Hospital Insurance Carrier _____ Policy/Group # _____

HEALTH HISTORY: (Write **Yes** or **No**)

Ear infections _____	Behavior problems _____	Special shoes _____	Asthma _____
Nose bleeds _____	Bleeding/clotting disorders _____	Chicken Pox _____	Poison Oak _____
Heart disease _____	Lyme Disease _____	Measles _____	Insect Stings _____
Diabetes _____	Hearing Aid _____	Rubella _____	Food _____
Seizures _____	Glasses _____	Mumps _____	Drugs _____
Fainting _____	Contact Lenses _____	Allergies: _____	Other _____
Bed-wetting _____	Dental braces _____	Hayfever _____	
Sleep walking _____	Orthopedic braces _____	Animals _____	Special diet _____

Details of any **Yes** above (especially allergic reactions to bee stings or food and how do you handle it at home?)

Recent operations or serious injuries _____ Date _____
 Hospitalizations _____ Date _____

Any known recent illness or exposure to contagious disease (within the last six weeks)? ____ Yes ____ No Details _____

Is the child currently under the care of a physician or psychologist? ____ Yes ____ No Details _____

Any activity restrictions at camp? _____

Has child menstruated? ____ Has she received information on menstruation? ____ Menstrual problems? _____

MEDICATIONS: Over the counter medicines will be used to treat routine illnesses at camp per doctor approved treatment procedures. Please list any over the counter medications that you **DO NOT** want your camper to receive. _____

List any medications being brought to camp with dosage and their purpose. Medication, both prescription and over-the-counter, **MUST** be in the original container; **camp CANNOT administer medication otherwise.** Prescription medication must be labeled with the camper's name and address and instructions.

MEDICATION	DOSAGE	PURPOSE
_____	_____	_____
_____	_____	_____

Camper's Name _____

Camp Name: Golden Timbers or Yosemite Camp of Service

This Health History is correct to the best of my knowledge, and the above camper has my permission to engage in all camp activities, including (check if applicable): _____ Sports _____ Canoeing _____ Swimming _____ Archery (only for 4th grade and above)

except as noted by me and/or the physician. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby authorize Girl Scouts, through the appointed camp medical personnel, to provide routine medical health care; to administer medications; and to order X-rays, routine tests as deemed advisable by a licensed physician. It is understood that every effort will be made to contact me or the person noted above before taking this action. I understand that this permission is given in advance of need for any diagnosis, treatment, or hospitalization. I give permission for this form to be photocopied for trips outside of camp.

Date _____ Signature of parent or legal guardian _____

You can help us ensure that our programs are meeting the needs of girls coming to our camps by providing the following information: (Please check the ethnic group with which your daughter most closely identifies.)

_____ White (not of Hispanic Origin) _____ Black (not of Hispanic origin) _____ Hispanic origin _____ Asian/Pacific Islander _____ Native American/Alaskan Native

ATTACH A COPY OF THE CAMPER'S IMMUNIZATION HISTORY OR PROVIDE IMMUNIZATION DATES

Immunization History	Year Primary Series Completed	Year of Last Booster	Immunization History	Year Primary Series Completed	Year of Last Booster
Diphtheria	_____	_____	Measles	_____	_____
Tetanus	_____	_____	Mumps	_____	_____
Whooping Cough	_____	_____	Rubella	_____	_____
Oral Polio	_____	_____	Other	_____	_____

PHYSICIAN'S STATEMENT

CODE: V = Satisfactory X = Not Satisfactory (Explain) O = Not Examined

Height	_____	Lungs	_____	Throat	_____	Hernia	_____
Weight	_____	Ears	_____	Heart	_____	Extremities	_____
Blood Pressure	_____	Nose	_____	Genitalia	_____	Posture (Spine)	_____
Eyes	R20/ _____ L20/ _____	With Glasses	R20/ _____ L20/ _____	Abdomen	_____	Skin	_____

General Physical and Emotional Status: _____

Special Problems or Significant Illnesses: _____

Special Diet: _____

Allergies: _____

Medications: _____

General Appraisal: _____

The health history and immunizations have been reviewed. There are no apparent contra-indications to participating in routine camp activities except as noted and no operations, serious illness, or injuries within the past 24 months.

Name PLEASE PRINT Physician, Physician's Assistant or Nurse Practitioner Signature Date

Address/City/State/Zip _____

Phone Number _____