2012 SHORT TERM RESIDENT CAMP GOLDEN TIMBERS GIRL REGISTRATION FORM

Please type or print. Complete this entire page. Mail the completed form along with the **$195.00 per camper fee (Checks should be made payable to Camp Golden Timbers – deposits of $75 or more are acceptable)** and a legal sized **stamped self-addressed envelope** to:

Camp Golden Timbers
Peitra Wivell, PO Box 1126, Columbia, CA 95310

Registration opens: March 1, 2012

Name of Camp : Golden Timbers Dates : July 29-August 2, 2012
Registration Closes : May 31, 2012

Name of Camper ______________________ Address ______________________

City ______________ State ______ Zip ______ Phone ______________

Age ______ Grade in Sept. ______ School ______________ Birthdate ______________

My daughter is currently : ☐ Girl Scout ☐ Non-Girl Scout

Local Girl Scout Council ______________________ Troop # ______

Parent 1 or Guardian 1 Name ______________ Telephone Number *(day)* ______________ Telephone Number *(evening)* ______________

Parent 2 or Guardian 2 Name ______________ Telephone Number *(day)* ______________ Telephone Number *(evening)* ______________

Parent 1/Guardian 1 E-mail (please print) ______________ Parent 2/Guardian 2 E-mail (please print) ______________

Parent/guardian's address during camp if different ______________________

Emergency Contact (other than parent/guardian) ______________ Telephone Number *(day)* ______________ Telephone Number *(evening)* ______________

Name of **ONE** girl your camper would like to have in the same unit. Both campers must request each other. **Submit forms together**; maximum of **TWO** registration forms per envelope. **Placement together cannot be guaranteed.**

Name: ____

Check if camper: ☐ Has earned Cookie Credits (Expected amount to be used: $__________) ☐ Cookie Card #__________________

☐ Has applied for financial assistance ☐ Full Payment ☐ Down Payment $_________(Must be at least $75.00) Final due by 6/11/2012

Please circle the appropriate T-Shirt size for your camper:

Child sizes – S (6-8) M (10-12) L (12-14) Adult sizes – S (34-36) M (38-40) L (42-44) 1X 2X 3X

As legal guardian of this child I give permission for her to attend camp and participate in all activities unless otherwise stated, for her to be transported out of camp during the camp session for programs and other purposes, and for emergency treatment to be given to her in case of injury or illness. I agree to cooperate with all regulations and procedures. I understand my daughter must have a current physical. I understand that if my daughter is not a currently registered Girl Scout by February 1, 2012, there is an **additional $12 fee which must be submitted along with the Girl Registration Form #6624**. I understand that this fee will be used to cover the cost of my daughter's membership registration.

When participating in Girl Scout camp, the camper may be photographed for print, video or electronic imaging. I understand that the images may be used in promotional materials, news releases, and other published formats for the local Girl Scout councils.

Signature of Parent/Guardian: ____

Form will not be processed without parent/guardian signature.

How did you hear about camp ? ☐ Internet ☐ Council Flyer ☐ Friend ☐ Troop Leader ☐ Previous Camper

Please remember to include a legal sized **stamped self-addressed envelope** along with this form and your check.
For non-Girl Scouts you must also include a Girl Registration/membership form #6624 and an additional $12.

Girl Emergency Health Information

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

This form is to be completed and signed by parents/guardians of the girl and updated annually.

Name ______________________ Birthdate______________ Troop # ______________________

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

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

Parent/Guardian ______________________ **Parent/Guardian** ______________________

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

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

Emergency Contacts (in the event parents cannot be reached)

Name ______________________ Name ______________________

Relationship ______________________ Relationship ______________________

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

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

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

Email ______________________ Email ______________________

The child may **NOT** be released to the following individuals:

Name ______________________ Name ______________________

Relationship ______________________ Relationship ______________________

Phone (_____) ______________________ Phone (_____) ______________________

Does the participant 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 the participant is allergic to and/or indicates whether the participant has special needs like asthma or diabetes.)

Please provide any information in relation to the care of the participant that would be useful to the adult in charge. Also indicate any activities to be encouraged or restricted. ______________________

The above information is correct to the best of my knowledge, and my daughter has my permission to engage in all activities, except as noted. **I hereby authorize Girl Scouts Heart of Central California, through the adult person(s) caring for my daughter, 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 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.** 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. For example, if a Girl Scout later develops an allergy or contagious disease or is no longer allowed to participate in a particular activity, the parent or individual must inform the troop or activity leader to ensure the safety of both the individual and those around her.

______________________ ______________________
Date Signature of parent/guardian

______________________ ______________________
Updated Signature of parent/guardian

______________________ ______________________
Updated Signature of parent/guardian

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

#655g – rev – 12/11 – LW:js

Transportation Arrangement Form

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

For Short Term Resident Camp Name: ____

This form must be completed and on file before your child may attend camp. Please return promptly to the registrar of the short term resident camp your child will be attending (registrar names and mailing addresses are located in the camp brochure). **List all people who might be picking up your child from Camp.**

Camper's First Name:	Camper's Last Name:
Nickname:	Home Phone: ( )
Home Street Address:	City:
Parent/Guardian Name:	Phone # during camp hours: Cell # Home# Work #

PARENT SIGNATURE:____

Adults authorized to **sign-out** my child are (**INCLUDE PARENTS**):

Name -	Relationship to child -
____________________	**PARENT**____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Please note that any adult picking up a child at the end of camp will be required to show **photo ID**.

Camper sign-out Log
(**to be completed** at camp by the adult when picking up the camper)

DATE	**SIGN-OUT** (signature of responsible adult)

#STRC 26– rev – 1/12 – LK:js

Consent to Administer Medication to a Minor

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

(overnight activities)

Form to be used one (1) time only

Name of minor_______________________________ Date(s) of event__________

Name of event ____

Prescription Medications

1. Each medication must be in its original pharmacy container and will be administered in accordance with the pharmacy label as prescribed.

2. Please use the attached page to authorize each prescription.

Non-Prescription Medications

Minors are not permitted to bring medications to Girl Scout activities. Consent must be provided by the parent or guardian in order for Girl Scout personnel to administer non-prescription medications. Please initial the following medications you authorize to be administered to your child as necessary.

______ Pain reliever (Tylenol®, Advil®, acetaminophen, ibuprofen)

______ Allergy and itch relief (Diphenhydramine: Benadryl®, Caladryl®, and Cortizone®)

______ Stomach remedies (antacids)

Are there any over the counter medications or first aid remedies that your child is allergic to or that you **do not** wish to be administered? ☐ Yes ☐ No

If yes, please explain ____

____

____

____

Sunscreen and Insect Repellent

Minors may bring their own insect repellent (containing 15% DEET or less) and sunscreen. Please indicate if you DO NOT give us permission to administer these items to your child.

Do not administer:____

____

The information provided in conjunction with this form is correct to the best of my knowledge. I authorize Girl Scouts to administer the prescription and non-prescription drugs noted herein. I acknowledge that in the event of an emergency, the use of some medication not previously approved may be necessary. In these circumstances, I authorize Girl Scouts to administer medication without prior approval. I agree to inform a troop or activity leader of any changes in the above information. For example, if a Girl Scout later develops an allergy or contagious disease or is no longer allowed to participate in a particular activity, the parent or individual must inform the troop or activity leader to ensure the safety of both the individual and those around her.

______________________ ______________________

Date Signature

#3509 – rev – 12/11 – LW:js

girl scouts

Prescription Medication Authorization

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

Name of Minor: ______________________________

Prescription Name	Prescribing Physician	Physician's Phone Number	Dosage	Time of Administration	Side Effects

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 ______________________________