

2012 SHORT TERM RESIDENT YOSEMITE CAMP OF SERVICE GIRL REGISTRATION FORM

Please type or print. Complete this entire page. Mail the completed form along with the **\$175.00 per camper fee** (Checks should be made payable to Girl Scouts Heart of Central California – deposits of \$75 or more are acceptable) and a legal sized stamped self-addressed envelope to:

Yosemite Camp of Service
Mickey Phillips, 3621 Forest Glenn Drive, Modesto CA 95355

Registration opens: March 1, 2012

Name of Camp : Yosemite Camp of Service Dates : July 9 – 13, 2012
Registration Closes : June 4, 2012

Name of Camper			Address		
City	State	Zip	Phone		
Age	Grade in Sept.	School	Birthdate	My daughter is currently :	
				<input type="checkbox"/> Girl Scout <input type="checkbox"/> 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)
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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



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

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 _____