



# COUNCIL PROGRAM REGISTRATION

Mail or deliver this form to any of the five Girl Scouts of Greater South Texas service centers.

This registration form will be returned unprocessed to you: if full payment does not accompany the form; if the form is incomplete or inaccurate; or if registration for the event listed is not yet open. If the registration form is returned to you, your spot at the event is not held. Refer to the GSGST Program Guide for additional information regarding registration and refunds.

**SUBMIT ONE FORM AND PAYMENT PER PROGRAM**

Event Name: \_\_\_\_\_

Event Date: \_\_\_\_\_ Event Location: \_\_\_\_\_

Person to receive confirmation: \_\_\_\_\_ Troop \_\_\_\_\_ SU \_\_\_\_\_

Address \_\_\_\_\_ City, ZIP \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Can we send your welcome packet by e-mail to save paper?  
 Yes       No

Indicate whether this is an individual registration or a troop/group registration:  
 Individual       Troop/Group

REGISTRATION FEES	Event fee per participant	# of Participants	Total
Girl / Child	\$		\$
Adult	\$		\$
PAYMENT MUST ACCOMPANY THIS FORM.		Total Payment	\$

PAYMENT BY CREDIT CARD

Please charge my:  Visa     MC     Discover    Credit Card # \_\_\_\_\_

Exp. Date \_\_\_\_\_ Billing Zip code \_\_\_\_\_ Security / V-Code \_\_\_\_\_

Print your name as it appears on your card: \_\_\_\_\_

Signature \_\_\_\_\_

**Troop Registrations only (all items must be checked):**

- I understand that participating troops must provide Essential Safety Adults (ESAs) to meet the girl/adult safety ratio unless otherwise noted in the program guide, *In Motion*.
- One or more of the Essential Safety Adults must be a First Aider with current First Aid and CPR certification. Copies of certifications must be submitted with each council program registration form.
- I understand that drivers for troop trips must be registered Girl Scout members and submit current copies of insurance and driver's license with each council program registration form.
- The leader will have a signed permission slip with photo permission and health history form for each girl in the troop/group on hand during the event.
- I have read and agree with the program information and the council's refund procedure.

**Individual Registrations only (all items must be checked):**

- A parent/guardian of my daughter/ward will be present at the event to supervise her, unless the event was designated as a "Drop Off" event in the program guide.
- I have read and agree with the program information and the council's refund procedure and give my daughter/ward permission to attend this event.
- I understand that photographs of participants at this event are the property of the Girl Scouts of Greater South Texas and may be used for publicity purposes including print and online media, and council publications.

Leader/Volunteer or Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



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**Participation Roster**

List each girl / child attending

Girl / Child First and Last Name	Grade	Special Accommodations/Needs

List the Essential Safety Adults attending, and any additional adults serving in the following capacities:

Adults First and Last Name	./Leader	./ Driver (Ins & DL)	./ First Aider (FA&CPR cert.)

**DRIVERS** must have current Insurance and driver's license attached to registration form.  
**FIRST AIDERS** must have current First Aid & CPR certification attached to registration form.

*Use an additional sheet if needed.*



# Confidential Health History

This form must be completed and signed by parents/guardians of girls or by adult members themselves. All health history forms will be held in limited access by the trustee (leader/facilitator/staff) of the specific Girl Scout program. The absolute minimal necessary information may be shared with program staff/volunteers in order to provide adequate care. The health history form will be retained by the Girl Scout program trustee until it is destroyed. This form must be signed. Duplicate this form as needed.

## SECTION A: MEMBER INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Troop # \_\_\_\_\_  
 Address \_\_\_\_\_ City, \_\_\_\_\_ ZIP \_\_\_\_\_  
 \_\_\_\_\_ Parent/Guardian \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
 Home Address \_\_\_\_\_ City, \_\_\_\_\_ ZIP \_\_\_\_\_  
 \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_  
 If Parent/Guardian is unavailable, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
 Name of Family Physician: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_ ID \_\_\_\_\_ Number \_\_\_\_\_  
 \_\_\_\_\_ Insurance Carrier's Contact Phone Number (\_\_\_\_\_) \_\_\_\_\_

## SECTION B: HEALTH HISTORY / RECURRING CONDITIONS / MEDICATION PERMISSIONS

Check each applicable item, giving appropriate dates and comments.

ALLERGIES / DESCRIPTION	ADDITIONAL INFORMATION	RECURRING CONDITIONS	DISEASES / DATES
D Foods _____	D Operation/Date _____	D Ear Infections _____	D Chicken Pox _____
D Insects _____	D Serious Injury/Date _____	D Heart Disease _____	D Measles _____
D Plants _____	D Sleepwalking _____	D Kidney Disease _____	D German Measles _____
D Drugs _____	D Bedwetting _____	D Convulsions _____	D Mumps _____
D Animals _____	D Fainting _____	D Bronchitis _____	D Scarlet Fever _____
D Hay fever _____	D Constipation _____	D Frequent Colds _____	D Rheumatic Fever _____
D Asthma _____	D Night Disturbances _____	D Frequent Sore Throat _____	D Poliomyelitis _____
D Latex _____		D Stomach Upset _____	D Whooping cough _____
D Other _____		D Diabetes _____	D Other _____
Date of last health examination _____/_____/_____		D Hyperactivity _____	
Were any complicating medical problems noted? _____		D Epilepsy _____	
Is participant now under the care of a physician / psychologist? _____		D Hearing Impairment _____	<b>OVER-THE-COUNTER MEDICATION PERMISSIONS</b>
List restrictions to swimming, diving, running, etc. _____		D Vision Impairment _____	My daughter/ward has permission to take or use the following upon recommendation by a First Aider:
Describe any medical/dietary regimen to be continued: _____		D Orthopedic Impairment _____	D Acetaminophen _____
		D Learning Disability _____	D Ibuprofen _____
		D Other _____	D Decongestant _____
Since last health examination, has the participant had:			D Antihistamine oral or cream _____
A serious illness requiring medical attention? _____			D Anti-diarrheal liquid or tablets _____
An illness lasting more than 5 days? _____			D Antacid tablets _____
A surgical operation or fracture? _____			D Expectorant _____
Treatment in a hospital or emergency room? _____			D Alcohol-vinegar solution ear drops _____
Any restrictions concerning physical activities? _____			D Other _____
Exposure to a contagious disease? _____ Within the past month? _____ What? _____			

## SECTION C: PARENT/GUARDIAN MUST COMPLETE THE INFORMATION BELOW

I have read the procedures for handling my daughter/ward's health history information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. In case of emergency, I give permission for the First Aider(s) to administer medication and/or First Aid AND give permission to an attending physician to hospitalize or secure proper treatment/surgery for me/my child. I give permission to transport me/my child to the nearest emergency facility for treatment. I know of no reason(s), other than the information indicated on this form, why I/my child should not participate in prescribed activities except as noted.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_