



Girl/Individual 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 program guide *In Motion* for additional information regarding registration and refunds.

HEALTH HISTORY FORM MUST ACCOMPANY PROGRAM REGISTRATION FORM

Event Name: _____

Event Date: _____ Event Location: _____

Girl Name _____ Troop / Juliette (if applicable): _____

Address _____ City, ZIP _____

Phone (_____) _____ E-mail _____

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

Level: DA BR JR CA SR AM Grade: _____ School: _____

I am currently a registered Girl Scout. I am registering now as a Girl Scout (add \$12)

Special needs / medical conditions: _____

Parent/Guardian: _____

| REGISTRATION FEES | Event fee per participant | Membership | 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 _____

- I have read and agree with the program information and refund procedure and give my daughter/ward permission to attend the event.
- 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.
- Yes No Any photographs or films taken in which my daughter/ward appears may be used for promotion or as deemed appropriate by the Girl Scouts of Greater South Texas Council including promotional material, publicity, and digital media, free of any claims on my part.

Parent/ Guardian Signature _____ Date _____

OFFICE USE: Date _____ Fee Amount _____ Rec'd by _____ Conf. _____



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 <input type="checkbox"/> Foods _____ <input type="checkbox"/> Insects _____ <input type="checkbox"/> Plants _____ <input type="checkbox"/> Drugs _____ <input type="checkbox"/> Animals _____ <input type="checkbox"/> Hay fever _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Latex _____ <input type="checkbox"/> Other _____ | ADDITIONAL INFORMATION <input type="checkbox"/> Operation/Date _____ <input type="checkbox"/> Serious Injury/Date _____ <input type="checkbox"/> Sleepwalking _____ <input type="checkbox"/> Bedwetting _____ <input type="checkbox"/> Fainting _____ <input type="checkbox"/> Constipation _____ <input type="checkbox"/> Night Disturbances _____ | RECURRING CONDITIONS <input type="checkbox"/> Ear Infections _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Kidney Disease _____ <input type="checkbox"/> Convulsions _____ <input type="checkbox"/> Bronchitis _____ <input type="checkbox"/> Frequent Colds _____ <input type="checkbox"/> Frequent Sore Throat _____ <input type="checkbox"/> Stomach Upset _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Hyperactivity _____ <input type="checkbox"/> Epilepsy _____ <input type="checkbox"/> Hearing Impairment _____ <input type="checkbox"/> Vision Impairment _____ <input type="checkbox"/> Orthopedic Impairment _____ <input type="checkbox"/> Learning Disability _____ <input type="checkbox"/> Other _____ | DISEASES / DATES <input type="checkbox"/> Chicken Pox _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> German Measles _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Scarlet Fever _____ <input type="checkbox"/> Rheumatic Fever _____ <input type="checkbox"/> Poliomyelitis _____ <input type="checkbox"/> Whooping cough _____ <input type="checkbox"/> Other _____ |
|--|---|---|---|

Date of last health examination ____/____/____
 Were any complicating medical problems noted? _____
 Is participant now under the care of a physician / psychologist? _____
 List restrictions to swimming, diving, running, etc. _____

Describe any medical/dietary regimen to be continued: _____

Since last health examination, has the participant had:
 A serious illness requiring medical attention? _____
 An illness lasting more than 5 days? _____
 A surgical operation or fracture? _____
 Treatment in a hospital or emergency room? _____
 Any restrictions concerning physical activities? _____
 Exposure to a contagious disease? _____ Within the past month? _____ What? _____

OVER-THE-COUNTER MEDICATION PERMISSIONS
 My daughter/ward has permission to take or use the following upon recommendation by a First Aider:

Acetaminophen
 Ibuprofen
 Decongestant
 Antihistamine oral or cream
 Anti-diarrheal liquid or tablets
 Antacid tablets
 Expectorant
 Alcohol-vinegar solution ear drops
 Other _____

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 _____