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. Girl Activity Refunds: Refunds may be issued with a minimum of TWO WEEKS cancelation notice to council by emailing mholland@gsgst.org or calling (956) 425-2388. The Troops or individual has the option to transfer to another GSGST activity or receive a refund. *Note: Consideration will be given in the event the request is the result of an illness, injury or death in the family. GSGST will determine if a refund is to be issued and if the refund will be full or partial.

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

OFFICE USE: Date________ Fee Amount________ Rec'd by__________ Conf. ________

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girl scouts of greater south texas

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

- ☐ Foods ________________
- ☐ Insects ________________
- ☐ Plants ________________
- ☐ Drugs ________________
- ☐ Animals ______________
- ☐ Hay fever ______________
- ☐ Asthma ________________
- ☐ Latex ________________
- ☐ Other ________________

ADDITIONAL INFORMATION

- ☐ Operation/Date ___________
- ☐ Serious Injury/Date ________
- ☐ Sleepwalking
- ☐ Bedwetting
- ☐ Fainting
- ☐ Constipation
- ☐ Night Disturbances

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:

____

RECURRING CONDITIONS

- ☐ Ear Infections
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Convulsions
- ☐ Bronchitis
- ☐ Frequent Colds
- ☐ Frequent Sore Throat
- ☐ Stomach Upset
- ☐ Diabetes
- ☐ Hyperactivity
- ☐ Epilepsy
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ Orthopedic Impairment
- ☐ Learning Disability
- ☐ Other ________________

DISEASES / DATES

- ☐ Chicken Pox ___________
- ☐ Measles ___________
- ☐ German Measles _________
- ☐ Mumps ___________
- ☐ Scarlet Fever ___________
- ☐ Rheumatic Fever _________
- ☐ Poliomyelitis ___________
- ☐ Whooping cough _________
- ☐ Other __________________

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 __________________

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? _____________________

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 __________________