



# Girl Scouts of Eastern Oklahoma Permission for Service Unit Non-Overnight Activity

I understand and am in complete agreement that:

1. my child \_\_\_\_\_ will participate and/or travel with Girl Scouts of Eastern Oklahoma \_\_\_\_\_ Service Unit at/to (location) \_\_\_\_\_ on (date/s) \_\_\_\_\_ ;
2. there will be \_\_\_\_\_ adults participating with/accompanying the \_\_\_\_\_ Girl Scouts;
3. my child will participate in (description of activities) \_\_\_\_\_ and/or will visit \_\_\_\_\_ ;
4. transportation will be by  private car  rented/chartered vehicle  other \_\_\_\_\_ ;

During this activity, I may be reached at the following locations in addition to the home phone:

Additional telephone number(s) – Guardian 1 \_\_\_\_\_

Additional telephone number(s) – Guardian 2 \_\_\_\_\_

In case I cannot be reached, someone to contact in an emergency will be (please notify these people of their responsibilities):

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

After this activity, my child will be going \_\_\_\_\_ with \_\_\_\_\_

### AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that my child should not attend meetings or special activities when she is ill or recently exposed to a contagious disease. If she should become ill or injured while in the care or under the supervision of Girl Scouts of Eastern Oklahoma, any of its officers or leaders, I authorize her to receive first aid and other emergency care. If it should become necessary for her to receive professional medical, surgical, or dental treatment, I authorize the responsible Girl Scouts of Eastern Oklahoma officer or leader to give the necessary "parental consent" in my stead for a licensed physician, surgeon or dentist to administer any medical, surgical or dental treatment they deem necessary, including hospitalization and surgery. I understand that every reasonable effort will be made to contact me immediately upon the discovery of the emergency. I further understand that I will take full financial responsibility for all expenses that might be incurred that are not covered by Girl Scout insurance.

Insurance provider for child \_\_\_\_\_ I.H.S. chart # (if applicable) \_\_\_\_\_

This consent is given in advance of any specific diagnosis or treatment being required, and is given primarily to encourage those officers or leaders who have temporary custody of my child, and the said physician, surgeon or dentist to exercise their best judgment in situations deemed an emergency as to the requirements of such diagnosis or medical, surgical or dental treatment.

**I have read the Authorization for Emergency Care and give my consent.**

*Signature of BOTH parents is required unless one parent has legal custody. Signatures must be in ink.*

PARENT'S/GUARDIAN 1'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

PARENT'S/GUARDIAN 2'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

**Please complete other side**

✂ *Clip here and keep this information for reference* ✂



**DON'T FORGET!!**

**GIRL SCOUT ACTIVITY**

**DO I NEED TO SEND MONEY?**

NO  **YES!** \$ \_\_\_\_\_

GOING TO \_\_\_\_\_ ON (date) \_\_\_\_\_

TIME AND PLACE OF DEPARTURE \_\_\_\_\_

SHE NEEDS TO BRING AND/OR WEAR \_\_\_\_\_

AT-HOME CONTACT NAME AND PHONE \_\_\_\_\_

**PICK HER UP! DAY/DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_ **PLACE:** \_\_\_\_\_