girl scouts

**Girl Scouts of Eastern Oklahoma**
**Parent Permission for Service Unit Overnight Activity or Trip**

**Please complete <u>both</u> sides. Your signature <u>must be in ink</u> on all the lines marked with X.**

**Name of Girl _____ Grade _____ Birthdate _____**

**Address _____ City _____ Zip _____ Home Phone _____**

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

Name and additional telephone number(s) – Mother _____

Name and additional telephone number(s) – Father _____

**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 _____

**Private Medical Insurance Information:**

Company _____ Group # _____ Other # _____

**I understand and am in complete agreement that:**

1. my daughter _____ will participate and/or travel with _____ Service Unit of Girl Scouts of Eastern Oklahoma at/to _____ on _____ for _____;
2. there will be _____ adults participating with/accompanying the _____ Girl Scouts; and that these adults will act in a parental role in my place;
3. my daughter will participate in _____ and/or will visit _____;
4. transportation will be by _____;
5. the cost is _____;
6. the group will stay in _____;
7. security provided by the facility is _____;
8. The Service Unit has made the following security arrangements: _____ _____.

**X Parent/Guardian SIGNATURE _____**

**X PRINT Parent/Guardian Name_____**

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

I understand that my daughter should not attend any activity 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.

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 daughter, 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.

By signing this permission document, I acknowledge that I have an opportunity to discuss all aspects of this activity, I fully understand the nature of this event and am in complete agreement. I have no further questions regarding it. I give my unreserved permission for my daughter to participate and for the adults to act in a parental role in my place.

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

**X Parent/Guardian SIGNATURE _____ Date _____**

**PHOTO RELEASE**

I hereby consent that photographs, video tapes, and/or motion picture film in which my daughter appears and/or audio recordings made of her voice may be used by Girl Scouts of Eastern Oklahoma and its assigns in whatever way they may desire, including television; I consent that any such photograph, film, recording, and the plates and/or tapes from which they are made, shall be the property of Girl Scouts of Eastern Oklahoma and that they shall have the right to duplicate and reproduce and make other such use of said materials as they may desire without any claim on my part.

**Your signature gives permission for the Council to use photographs of your daughter.**

**X Parent/Guardian SIGNATURE _____ Date _____**

**HEALTH HISTORY FOR (PLEASE PRINT GIRL'S NAME):** _____

**Name of Family Physician** _____ **Phone** _____

**Date of last Tetanus Shot** _____ **Date of last Health Examination** _____

**Illnesses and injuries (check all that apply):**

- ○ Ear infection
- ○ Hypertension
- ○ Seizures
- ○ Asthma
- ○ Other _____
- ○ Bleeding/clotting disorders
- ○ Musculoskeletal disorders
- ○ Heart defect/disease
- ○ Diabetes

**Allergies (check all that apply; specify nature of reaction):**

- ○ Animals _____
- ○ Pollen _____
- ○ Hayfever _____
- ○ Food _____
- ○ Plants _____
- ○ Insect bites/stings _____
- ○ Medicine/drugs _____
- ○ Other (Specify): _____

**Other conditions (check all that apply):**

- ○ Bed wetting
- ○ Constipation
- ○ Menstrual cramps
- ○ Motion sickness
- ○ Nosebleeds
- ○ Wears glasses/contact lenses
- ○ Other _____
- ○ Emotional disturbances
- ○ Fainting
- ○ Hearing impairment
- ○ Sickle cell trait/disease
- ○ Sleep disturbances

**Special dietary regimen (such as lactose intolerance, vegetarianism, and religious considerations):** _____

**Activities to be encouraged or restricted:** _____

**I know of no reason(s) other than the information given on this form why my daughter should not participate in the activities noted.**

***X*** **Signature of Parent/Guardian (MUST BE IN INK)** _____

**HEALTH INFORMATION PRIVACY STATEMENT**

The **Girl Health Examination Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The sponsoring council or GSUSA will retain the health form until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but the participant or their legal representative may request copies from the event sponsor. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. *If, due to religious affiliation, you cannot give authorization for emergency medical care, please attach a letter of confirmation from a church official.*

***X*** **PARENT'S/GUARDIAN'S SIGNATURE** _____ **DATE** _____

## PERMISSION FOR MEDICATION

If your child needs medication while attending a council overnight or trip, medication must be in the original, labeled container. The label should be legible and contain the following information: patient name; physician's name; name of medication; dosage amount and administration; special precautions/instructions, if any; pharmacy name and telephone; prescription number and refill information. Over-the-counter medication must also be in the original container, clearly labeled and marked with the child's name and dosage instructions.

I hereby give permission for the administration of the following over-the-counter medications if deemed necessary by a qualified first aider, nurse or physician. Dosages will be administered according to directions on the bottle unless otherwise directed by a physician.

**Please (✓) any medication your child MAY be given.**

☐ ACETAMINOPHEN ☐ ANTIBIOTIC OINTMENT ☐ CHEWABLE ANTACID TABLETS

***X*** **PARENT'S/GUARDIAN'S SIGNATURE** _____ **DATE** _____

I am sending the following medication(s) with my child:

| | **Medication** | **Directions** |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

## FIRST AIDER/NURSE'S RECORD OF MEDICINE ADMINISTERED

| Date/Time | 1. | 2. | 3. | 4. | 5. |
|---|---|---|---|---|---|
| | | | | | |
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