

## ANNUAL PARENT/CAREGIVER PERMISSION & GIRL/ADULT HEALTH HISTORY FORM

Girl Scouts of Silver Sage 8948 W Barnes St, Boise, ID 83709 (208) 377-2011 or (800) 846-0079 www.girlscouts-ssc.org

This form obtains health information for both girls and adults and parent/caregiver permission for all troop meetings, events, and activities for the Girl Scout year, *excluding planned meetings dealing with sensitive issues, overnights, and/or high-risk activities as defined by Safety Activity Checkpoints.*Troop leaders agree to inform parents, in print or electronically, when an activity is away from the normal meeting site. With the use of this form, additional permission forms are not required for troop events or activities unless requested by the vendor or the event planner or as referenced above.

Membership	Year October 1, 20 September 30, 20	_	
Girl Scout Na	me	Troop #	_Service Unit #
Address		_ City	State Zip
Name of Pare	ent/Caregiver 1	Relationship to Girl _	
Email Addres	ss	_ Mobile Phone	
Name of Parent/Caregiver 2		Relationship to Girl	
Email Addres	ss	_Mobile Phone	
Emergency Contact Name		Mobile Phone	
Relationship	to Child		
event activit	activities, I will be notified by the troop l y, location, place and time of departure/r clothing needed, amount of money per gir	eturn, mode of transpo	ortation,
□ Yes □ No	Permission for Activities – My girl has pobooth activities for the product programs council-sponsored activities. If the activit submit to Council the Intent to Travel for activity is a high-risk activity as defined by required to have each parent complete the Initials	, travel to/from, attend y is an overnight stay, t m at least 4 weeks befor y Safety Activity Check	, and participate in the troop is required to re the activity. If the apoints, the troop is
□ Yes □ No	Permission to Use Photographs – I under activities, my girl may be photographed fo in promotional materials, news releases, a that the images may be the sole property of Scouts of the USA. I hereby consent that m troop/Council for public relations, publicit understand that her last name and resider Initials	or print, video, or electro nd or other published for of the troop, Girl Scouts ny girl's images may be ty, and/or personal troo	onic imaging to be used formats. I acknowledge of Silver Sage, or Girl used by the

Parent/Caregiver Responsibility: It is your responsibility to support your girl's troop by:					
☐ Supervising your child be	efore and after Girl Scout activities -	- never leave her unattended. The troop leader(s)			
is not responsible for your girl before or after the troop/Council activity.					
☐ Picking your child up at the scheduled pick-up time or end-of-meeting time.					
☐ Informing the troop Leader(s) if your child will be absent for the troop/Council meeting/activity.					
☐ Informing the troop Leader(s) of any change in contact information for yourself or any of the emergency contacts.					
	eeting unless I am an approved volur	nteer (having a current Girl Scout registration and			
	•	assist with the troop meeting/activity.			
	eeting with non-Girl Scouts (includin				
	oung winning on recours (moraum	is martie of ortain ormations,			
Signature of Parent/Caregiv	ver	Date			
(	GIRL/ADULT HEALTH I	JISTODV FODM			
•	JIKE/ADOLI HEALIHI	IISTORT FORM			
Permission to Obtain Emergency Medical Treatment – In the event of an emergency, every effort will be made to contact me, or the emergency contact listed on this form. I hereby give authorization to the troop leader(s) and Girl Scouts of Silver Sage to seek treatment for my girl by a licensed physician or hospital. I know of no reason why my child may not participate in the activity except as noted on the Health History Form. If permission for emergency medical treatment is not given, I will prepare a signed statement providing the reason, a release of liability, and alternate instructions, and attach it to this form.  Initials					
GIRL Information					
Girl First Name	Middle Name	Last Name			
Name of Family Physician		Phone			
Family Medical/Hospital Ins	surance Carrier	Policy or Group #			
Family Dental Insurance Ca	arrier	Policy or Group #			
Age Birthday	Immunizations	s are up to date $\square$ yes $\square$ no $\square$ N/A			
Date of last Tetanus shot	/ / Da				
		te of last health examination / /			
Were there any medical pro	oblems at the time?				

Has the participant had any recent injuries or surgery? $\Box$ yes $\Box$ no. If yes, please expla	in and specify the date:
Does the participant take any prescribed medications on a regular basis? $\Box$ yes $\Box$ no If yes, please state the medication and reason:	
Is the participant restricted or limited from participating in any physical activity $\Box$ yes If yes, please explain	□no
Participant has the following health conditions/allergies (food and medications)  □ADHD □Asthma □Diabetes □Headaches □Seizures □N/A	
OtherAllergies (specify)	
IF ADULT IS TROOP VOLUNTEER - ADULT Information	
Adult First Name Middle Name	Last Name
Name of Family Physician	Phone
Family Medical/Hospital Insurance Carrier	Policy or Group #
Family Dental Insurance Carrier	Policy or Group #
Age Birthday Immunizations are up to date	no □N/A
Date of last Tetanus shot / / Date of last health examination	on / /
Were there any medical problems at the time?	
Has the participant had any recent injuries or surgery? $\Box$ yes $\Box$ no. If yes, please expla	in and specify the date:
Does the participant take any prescribed medications on a regular basis? $\Box$ yes $\Box$ no If yes, please state the medication and reason:	
Is the participant restricted or limited from participating in any physical activity $\Box$ yes If yes, please explain	□no
Participant has the following health conditions/allergies (food and medications)  □ADHD □Asthma □Diabetes □Headaches □Seizures □N/A	
Other	
Allergies (specify)	