

Girl Scouts of Western Washington
Permission for Troop Meetings, Day Trips and Medical Care

Troop # _____ Girl's Name _____

SAFETY AGREEMENT FOR TROOP MEETINGS

- 1 Will your daughter be walking home from troop meetings? Yes No
- 2 Will someone be driving her home from troop meetings? Yes No
3. What is the name and phone number of the person who will drive her home?

4. Will anyone else have your permission to drive or walk her home?
Name & phone number: _____
5. Is there anyone who is NOT permitted to pick up your child?
Name: _____

I understand that if my daughter is to have a ride home, I am responsible for seeing that the person I named in questions 3 or 4 above is there by _____ p.m. to pick her up. (I understand that neither the leader nor Girl Scouts is responsible for driving her home or walking with her.

Signature of Parent or Guardian

Today's Date

PERMISSION FOR ALL ONE DAY TRIPS FOR THE YEAR

Throughout the year, there will be troop meetings and field trips held outside the normal meeting space. Your signature will give permission for all of our troop's local activities, including any field trips *of one day or less*. You will be informed in writing (handout or email) at least one week in advance of each field trip so you can let the leader know if you do NOT want your daughter to participate. If the leader does not hear from you, she/he will assume based on your signature below that your daughter has your permission to participate. You will need to complete individual permission slips for any troop activities over one day in length.

I agree to the Day Trip permission statement above.

Signature of Parent or Guardian

Today's Date

CONSENT OF PARENT OR GUARDIAN FOR MEDICAL TREATMENT

I am the parent or guardian having legal custody of the child named above. I authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment.

Signature of Parent or Guardian

Today's Date

Please fill out the information below and on the reverse side.

Child's Physician: _____ Physician's telephone number: _____
 Physician's address: _____
 Name of custodial parent(s) or legal guardian: _____
 Home, work or cell phone numbers: _____
 Alternate person(s) to contact in emergency: _____

Name: _____ Work Phone _____ Home phone _____ City _____ Relationship _____

CHILD'S MEDICAL STATEMENT

Girl's Name: _____ Birth Date: _____

CHRONIC ILLNESSES: CHECK IF APPLICABLE

- | | | | | | |
|-----------------------------|--------------------------|-------------------------------|--------------------------|----------------------|--------------------------|
| Disease of Kidneys | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> |
| Eyesight Impairment | <input type="checkbox"/> | Pneumatic Fever | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Hearing Impairment | <input type="checkbox"/> | Abnormal Blood Pressure | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Speech Impairment | <input type="checkbox"/> | Mental or Emotional Disorders | <input type="checkbox"/> | Hernia | <input type="checkbox"/> |
| Disorders of Nervous System | <input type="checkbox"/> | Ear Infection | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> |
| Sinusitis | <input type="checkbox"/> | Severe Menstrual Pain | <input type="checkbox"/> | Intestinal Disorders | <input type="checkbox"/> |
- Other-Please Specify: _____

CHILDHOOD DISEASES: CHECK IF APPLICABLE

- Chicken Pox Measles Mumps German Measles

ALLERGIES & IMMUNIZATIONS: CHECK IF APPLICABLE

<u>Allergies</u>	<u>Treatment & Reaction</u>	<u>Immunization</u>	<u>Year Primary Series Completed</u>	<u>Year of Last Booster</u>
<input type="checkbox"/> Hay Fever	_____	DPT	_____	_____
<input type="checkbox"/> Asthma	_____	Diphtheria	_____	_____
<input type="checkbox"/> Drugs	_____	Pertussis(Whooping Cough)	_____	_____
<input type="checkbox"/> Insect Stings	_____	Tetanus	_____	_____
<input type="checkbox"/> Poison Ivy	_____	Oral Polio	_____	_____
<input type="checkbox"/> Poison Oak	_____	Measles	_____	_____
<input type="checkbox"/> Food	_____	Mumps	_____	_____
<input type="checkbox"/> Animals	_____	Hepatitis B	_____	_____

COMMENTS (WHERE APPLICABLE)

Operations, serious injuries, or concussions (dates): _____

Hospitalizations: _____

Subject to fractures, sprains, or dislocations? _____

- Fainting Sleep Disturbances Menstruation Problems Constipation

Other: _____

Regular medication (on troop trips medicine MUST be in pharmacy container with name and directions for administering on the label): _____

Dietary restrictions: _____

This record will be retained by the troop leader for one year and accompany the adult in charge at all troop meetings and other activities (i.e. field trips, troop camping, etc).