girl scouts of western washington

Girl Scout Permissions & Health History

To be completed and signed by parent/guardian of Girl Scout youth

Contact Information		
Child's Full Name:	Date of Birth:	Age:
Address:		
Parent/Guardian Name:	Phone:	Email:
Physician's Name:	Phone:	
Emergency Contact:	Phone	Relationship:

Health Insurance Information – In case of accident or illness, personal insurance is primary, Girl Scout insurance is secondary.	
Policy Holder Name:	Insurance Company:
Policy Number:	Insurance Company Address:
Group Number:	Insurance Company Phone Number:

Pick up information – Name of person (s) authorized to pick up your child:	
Name	Phone Number
Names of Person(s) NOT permitted to pick up your child:	
If applicable, can your child walk home? ☐ Yes ☐ No	

Medical History – Check all that apply		
☐ Arthritis	☐ Fainting / Dizzy Spells	☐ Musculoskeletal Disorders
☐ Asthma	☐ Headaches / Migraines	☐Mental / Psychological Disorders
☐ Bedwetting	☐ Hearing Impairment	☐ Nosebleeds
☐ Bleeding Disorder	☐ Heart Defects/ Disease	☐ Sinusitis (Sinus Infections)
☐ Convulsions /Epilepsy/Seizures	☐ Hernia	☐ Sleep Disturbances
☐ Diabetes	☐ Hypertension / High Blood Pressure	☐ Sleep Impairment
☐ Diseases of the Ear or Ear Infections	☐ Intestinal Disorders / Constipation	☐ Speech Impairment
☐ Eating Disorders	☐ Kidney / Bladder Disease	☐Surgery / Hospitalized in last 5 days
☐ Eyesight Impairment	☐ Menstruation has started	☐ Under Physician / Psychologist care

	☐ Menstrual Cramps	☐ Other:
Date of last health exam:	Were any complication medical problems noted in last health exam? ☐ Yes ☐ No	
Please explain in detail any items checked above:		
My child's immunizations are up to date in accordance with Washington State requirements for public schools: ☐ Yes ☐ No, state reason(s):		
DTP or DT (Tetanus) Date:		

Allergies - List ALL allergies (including medications, food, bees, etc.), the type of reaction/severity, treatment and date of last reaction.

Allergies	Reaction/Severity	Treatment	Date of Last Reaction

Comments:

Does your child suffer from Anaphylaxis?* ☐ Yes ☐ No

*A severe allergic reaction marked by swelling of the throat and/or tongue, hives, and trouble breathing.

Do they carry an EpiPen? ☐Yes ☐No Do they carry an inhaler? ☐Yes ☐No

Over the Counter Medications & Dietary Restrictions

☐ My child does not have permission to take over the counter medication (please include any over the counter medication allergies above).

☐ My child can take the following over the counter medications daily or in case of accident/injury/sickness (for example pain reliever, digestive relief, etc.) Please include dosage as necessary.

Special Consideration or Notes:

My child has the following dietary restrictions:

My child takes prescription medication: ☐ yes ☐ no If yes, complete Section 2 of this form.

Initial & Sign	
	I understand that if my child is to have a ride home, I am responsible for seeing that the person I named above is there by _____ p.m. to pick them up. (I understand that neither the volunteer nor Girl Scouts is responsible for driving them home or walking with them.
	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. I will take full responsibility for all charges that occur. Girl Scout insurance is secondary to your primary insurance.
	I know of no reason (s), other than the information indicated on this form, why my child should not participate in activities except as noted.
	For Troop - Throughout the year, there will be meetings and field trips held outside the normal meeting space. Your signature will give permission for all of our group's local activities, including any field trips of one day or less. You will be informed in writing at least one week in advance of each field trip so you can let the leader know if you do NOT want your child to participate. If the leader does not hear from you, she/he will assume based on your signature below that your child has your permission to participate. You will need to complete individual permission slips for any activities over one day.
	Virtual Troop Meetings – by initialing this box you are giving permission for your child to participate in virtual meetings hosted online via platforms like Zoom.
	Recording of Virtual Girl Scout Events or Meetings – by initialing this box you are agreeing you understand that if your child attends a GSWW event or troop meeting, the meeting host will indicate if the meeting is being recorded, allowing you to choose your level of participation.
	The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact, by contact with contaminated surfaces and objects, and possibly in the air. People reportedly can be infected and spread the disease even if they do not show any symptoms. Girl Scouts of Western Washington ("GSWW") is committed to taking precautions to mitigate that risk as well as to following applicable federal, WA State, local and GSUSA COVID-19 directives and guidelines. Our council is also committed to having in-person activities as allowed and in accordance with those mandates. GSWW's operations and programs occurring while COVID-19 is circulating in our community may expose our members, volunteers, and employees to the risk of infection. GSWW cannot prevent you from becoming exposed to, contracting or spreading COVID-19 while attending (which includes being present in any capacity) any GSWW in-person programming. Therefore, any interaction with others in connection with in-person programming may expose you and your family to and increase your risk of contracting or spreading COVID-19. GSWW has put in place preventative measures to reduce the spread of COVID-19 at its in-person programming; however, GSWW cannot guarantee that you will not become infected with COVID-19. By participating in these in-person activities, participants will be viewed as: 1.) Understanding that COVID-19 is a highly contagious virus, easily spread including through in-person contact; 2.) Acknowledging that GSWW cannot guarantee that infection will not occur; 3.) Choosing to accept the risk of contracting COVID-19 for the participant and their family in order to attend the in-person activity; and 4.) Agreeing to release GSWW from responsibility in the event of COVID-19 infection. Participants who do not agree to these statements should not join in-person GSWW activities.
Parent/Guardian Signature:	**Date:**
Parent/Guardian Signature *(year 2 optional)*:	**Date:**

Section 2 – Prescription Medication Form

To be signed by physician and parent/guardian if prescription medications are administered

Prescription Medication

List any medications including dosage schedule and specific instructions for use. ALL prescriptions must be in the original container with appropriate label. *If traveling please provide extra written prescription(s) from the doctor with the generic name for all medications in case the original prescription is lost or a new one needs to be obtained.*

Medical Condition	Medication	Dosage	Dosage instructions (When and How often)	Special Storage Requirements

Other:

Special considerations or notes:

Parent/Guardian Signatures – Initial and Sign

	I am the parent/legal guardian of _____, a registered Girl Scout who has a medical condition that requires that she take prescription medication. Throughout the course of the year, my child also may take over-the-counter medications as needed. Because I will be unable to be with them at the time they need to take prescription I give_____[name of troop leader or authorized volunteer] permission to administer the following medication to my child or legal ward according to the instructions of their medical provider:
	I understand I am responsible for assuring that all medications I give to the volunteer are not expired. I further understand that the troop leader or volunteer helping me in this regard is not required to undertake this responsibility, and that he or she may discontinue doing so upon giving notice to the Girl Scouts of Western Washington and me.
	I have reviewed the Girl Scouts of Western Washington policy on administering medication to a minor.

Signature: Date:

Printed Name: Phone Number: Email:

Medical Provider Signatures – Written authorization and instruction from medical provider regarding administering medications

I am familiar with the medical condition of _____ (name of Girl Scout), who is a patient of _____ (name of office or clinic). I understand that the purpose of this form is to allow a Girl Scouts of Western Washington volunteer to administer medication to the above named child, and believe that he/she/they should be able to follow the instructions listed below without any further training and without detriment to the Girl Scout. _____ (name of Girl Scout) has the condition(s) set forth above that require that they take medication that has been prescribed by this clinic or by me. The volunteer who administers the medication should keep it in its original, marked container, should store it out of reach of other children, and should give the Girl Scout the medication in the dosage and according to the schedule set forth above.

Are there any OTC medications that are contraindicated for this Girl Scout? ☐ Yes(list here): ☐ No

If the volunteer has any questions or observes the Girl Scout having any of the following symptoms, the volunteer should contact this office or another qualified medical provider immediately.

Signature of Physician: Date:

Printed Name: Phone Number: Emergency Number: