girl scouts of western washington

Permission for Meetings, Day Trips and Medical Care

Girl's Name: _____ Birth date: _____

SAFETY AGREEMENT FOR MEETINGS

1 Will your daughter be walking home from meetings? ☐ **Yes** ☐ **No**

2 Will someone be driving her home from 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 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 (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 activities over one day.

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	*Primary Phone*	*Secondary Phone*	*City*	*Relationship*

MEDICAL STATEMENT

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

Girl's Name: _____ Birth date: _____

Medical History [Check all that apply]			
☐	Arthritis	☐	Hernia
☐	Asthma	☐	Hypertension/High Blood Pressure
☐	Bedwetting	☐	Intestinal Disorders/Constipation
☐	Bleeding disorder	☐	Kidney/bladder illness
☐	Convulsions/Epilepsy/Seizures	☐	Menstrual cramps
☐	Diabetes	☐	Musculoskeletal Disorders
☐	Diseases of the Ear or Ear Infections	☐	Mental/psychological disorder
☐	Eating Disorders (Anorexia, Bulimia, etc.)	☐	Nosebleeds
☐	Eyesight Impairment	☐	Sinusitis (Sinus Infections)
☐	Fainting/dizzy spells	☐	Sleep Disturbances
☐	Headaches/Migraines	☐	Sleep Impairment
☐	Hearing Impairment	☐	Had surgery or hospitalized in the last 5 years
☐	Heart Defects/Disease	☐	Currently under doctor or psychologist's care
☐	Other:		

Allergies

Allergies	Reaction/Severity	Treatment	Date of Last Reaction

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

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

Does she carry an Epipen? ☐ **Yes** ☐ **No** **Does she carry an inhaler?** ☐ **Yes** ☐ **No**

Record of Immunization [Must be completed in detail]

Immunization	Date Series Completed	Year of Last Booster	Immunization	Date Series Completed	Year of Last Booster
Hepatitis B			Hepatitis A		
Diphtheria, Tetanus, Pertussis (DTap/Tdap)			Inactivated Poliovirus (IPV)		
Measles, Mumps, Rubella MMR)			Influenza		
Rotavirus (RV)			Varicella		
Haemophilus influenzae type b (Hib)			Meningococcal (MCV)		
Pneumococcal (PCV)			Human Papillomavirus (HPV)		
Tuberulin Test: Result: Date:			**Other:**		

Medications and Dietary Restrictions

My child is taking the following prescribed and/or over-the-counter (OTC) medications:

I have reviewed the Girl Scouts of Western Washington policy on administering medication to a minor and submitted the appropriate permission forms to the adult in charge. ☐ **Yes** ☐ **No** ☐ **N/A** - My child is not currently taking any prescribed or OTC medications.

My child has the following dietary restrictions: