



TEEN

2018 Day Camp Information

Camp Name:

Service Unit:

Dates:

Camp Times:

Location:

Bus Information:

Optional Overnight:

Camp Description:

How to Register:

Camp Director:

CAMP INFORMATION

Health & Safety

All Girl Scout safety standards are met at camp. A certified first-aider is on duty at all times and arrangements have been made with local emergency services. Complete the registration and health forms with current and accurate information. All medical information will be kept confidential and accessed on a need-to-know basis only. This will help us meet the needs of all campers. Parent/Guardian signature is required to give permission for emergency medical treatment.

Severe Weather

Each camp has an action plan to respond to all forms of inclement weather. Please contact your Day Camp Director for specific information.

Transportation

Busing is required for all camps on a council-owned property. Due to limited parking at council-owned camps, all girls and adult volunteers are strongly encouraged to travel via bus.

Financial Assistance

The Opportunity Fund, formerly financial assistance, provides support for individuals or families with significant financial obstacles that may otherwise prevent them from participating in Girl Scouts. Any registered Girl Scout may apply for funding by submitting an opportunity fund application online at gsksmo.org/oppfund. Questions? Email opportunityfund@gsksmo.org.

Refunds

Refunds are not made if an individual cancels. If camp is cancelled, all fees except Girl Scout membership dues will be refunded.

Camp Clothes

Camp is an outside activity. Dress your camper in old clothes appropriate for the weather. We recommend a hat, bandana, socks and sturdy shoes. **LEAVE FLIP FLOPS AND SANDALS AT HOME.**

Equipment & Supplies

Additional Camp Information



Girl Scouts of NE Kansas & NW Missouri Council actively seeks and supports participation by all girls with a variety of interests and abilities in Girl Scout programs. Please contact the council office at (816) 358-8750 to let us know how we can serve you and/or your girl.

TEEN HEALTH FORM

Complete the health form, medication form (reverse) AND the attached registration form. These forms are processed separately with all medical information kept confidential.

Name: _____ Troop#: _____

Address: _____ Age: _____

City/State/ZIP: _____

Email: _____

Current Grade (at this registration): _____ GS Program Level (if applicable): D BR JR CA SR AM

Parent/Guardian 1: _____ Phone: _____

Parent/Guardian 2: _____ Phone: _____

REQUIRED:
Emergency Contact: _____ Phone: _____

Contact other than those listed above

Family Physician: _____ Phone: _____

My child may be released to: _____

Date of last health exam: _____ Date of last tetanus inoculation: _____

Chronic or recurring illness: Allergies:

- | | | |
|------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Heart defect/disease | <input type="checkbox"/> Animals: _____ | <i>Please list date of last known reaction; describe reaction type and severity (i.e. rash, anaphylactic shock etc.)</i> |
| <input type="checkbox"/> Bleeding/clotting disorders | <input type="checkbox"/> Medicines/drugs: _____ | |
| <input type="checkbox"/> Musculoskeletal disorders | <input type="checkbox"/> Plants: _____ | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hay fever: _____ | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Food: _____ | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Insect stings: _____ | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other (specify): _____ | |
| <input type="checkbox"/> Other (specify): _____ | _____ | _____ |

Activity Permissions: If offered, my child has permission to participate in the following activities (check all that apply):

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Activities to be restricted:

Anything else we should know about your child?

All medical information will be kept confidential and accessed on a need to know basis only.

*If you prefer to communicate health information directly to the Health Supervisor, contact the Camp Staff.

My child is in good physical condition except as indicated above, if applicable and has not had any serious illnesses or operations since her last health examination. I give permission for my child to attend camp and participate in all activities except those indicated above. I have read the camp flyer and agree to cooperate with all regulations. You have my permission to administer or authorize emergency medical treatment, although you will make reasonable efforts to contact me/my emergency contact. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. If my child should have a serious illness or operation or be exposed to contagion between the date this form is signed and the opening of camp, I will notify the director or the council office. This information is correct to the best of my knowledge.

Parent/Guardian Signature:

Date:

MEDICATION PERMISSION FORM

Name: _____ D.O.B.: _____ Grade: _____
Weight: _____

Over-the-Counter Medication

By initialing below, I give permission for personnel to administer the following medication(s) as needed for minor discomfort or injury.

Parents/guardians can also supply other over-the-counter medications. Please list below:

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Prescription Medication

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

To ensure continuity of care, I give permission for the Health & Safety Coordinator to communicate with the healthcare provider regarding medication administration.

Physician Name: _____ Phone: _____

Physician Signature (*required if no Rx label*): _____ Date: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

PLEASE NOTE: All medication sent to camp must be in original containers with girl's name on it.