

Please Mail Completed form along with \$7 to: Girl Scouts of the Nation's Capital, Attn: Nature Exploration, 801 Sycolin Road SE, Suite 202, Leesburg VA 20175, For more information contact Desiree Gale at dgale@gscnc.org or 703-777-5644 ext 203

Name of Friend Attending \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

If divorced or legally separated, please indicate the custodial parent(s): \_\_\_\_\_

**Must have information for emergency contact** if parent(s) cannot be reached (please print clearly):

Name/ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Current school attending: \_\_\_\_\_ State: \_\_\_\_\_ Grade: \_\_\_\_\_

Are you Currently registered as Girl Scout? Yes No Troop # \_\_\_\_\_

*We encourage you voluntarily to provide the following information on racial background and ethnicity. This information will be used by Girl Scouts of the USA to help improve outreach efforts and advance the Girl Scout movement.*

The registrant's racial background is: (Please check as many as apply)  American Indian or Alaskan Native  Asian  
 Black or African American  Hawaiian Pacific Islander  White  Other \_\_\_\_\_

The registrant's ethnic background is: (please check one)  Hispanic or Latina  Not Hispanic or Latina

## HEALTH HISTORY

*To be completed for ALL participants. Please use additional sheet to describe symptoms of allergies and details of illnesses or health restrictions.*

**Allergies:** \_\_\_\_\_

Please specify any accommodations that are needed: \_\_\_\_\_

**Disabilities:**  ADD/ADHD  Emotional Disability  Learning Disability  Physical Disability  Visual Disability  Hearing Disability  
 Behavioral Problems  Other \_\_\_\_\_

Please specify any accommodations needed: \_\_\_\_\_

Operations or serious injuries: \_\_\_\_\_ Dates: \_\_\_\_\_

**Immunization History:** Are all immunizations up-to-date?  Yes  No DTP or DT (Tetanus) Date: \_\_\_\_\_

If immunizations are not up to date, including the DTP, please submit a state certificate from physician or parent stating medical or religious reason.

**Medication Information:** Any prescribed medication being taken?  Yes  Inhaler  Epipen  No

If yes, please list medication and dosage: \_\_\_\_\_

### General Information – Please fill out all information

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Parent/Guardian Permission Statements

The health history on the reverse side is correct so far as I know, and the person herein described has my permission to participate in all prescribed activities as noted. If she/he appears to be ill, I will not send her/him to the program.

**EMERGENCY AUTHORIZATION:** I hereby give permission to the medical personnel selected by the director or her/his designee to order x-rays, routine tests and treatment for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director or her/his designee to hospitalize, secure proper treatment for, and/or order injection and/or anesthesia and/or surgery for my child as named above.

The council may use photographs in which my child appears to promote Girl Scouting: Yes No

I understand my daughter will become a registered member of Girl Scouts of the USA through participation in this program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Registration is invalid without a parent/guardian signature**

Financial Assistance:

The program fee is \$15.00 our family can pay \$ \_\_\_\_\_ therefore we are requesting \$ \_\_\_\_\_ in assistance