

Girl Scouts of Southern Illinois

www.gssofsi.org

Corporate Service Center
#4 Ginger Creek Parkway • Glen Carbon, IL 62034
(618) 692-0692 • (800) 345-6858 • fax: (618) 692-0685

Program Registration For Individuals

Name of Event _____ Code _____

Date of Event _____ Time of Event _____

If choice of sessions, list: 1st _____ 2nd _____ 3rd _____

Leader/Facilitator _____ Troop # _____ Service Unit # _____ GS Grade _____

Girl Name _____

Address _____

City _____ ST _____ Zip Code _____

Phone # (Day) _____ (Evening) _____

E-Mail _____

Additional Information _____

Program Cost \$ _____

PAYMENT: Check enclosed: # _____ Amount \$ _____
 Mastercard Visa Discover

Card Number _____ Expiration Date _____

Amount \$ _____ Signature _____

PARENT'S CONSENT:

I request that my daughter/ward _____ attend the _____
at _____ and participate in all phases of the activities. I agree to cooperate with
all of Girl Scouts of Southern Illinois regulations. Further, Girl Scouts of Southern Illinois has my permission to
use photographs or videotapes of my daughter/ward for whatever purposes they see fit, including website, with
no claim whatsoever on my part.

Health history form on back has been completed.

Signature of parent/guardian _____ Date _____

Girl Scouts of Southern Illinois

Girl & Adult Health History Record

This health history is to be completed and signed by parents/guardians of girls or by adult members themselves

Name _____ DOB _____ Age _____

Address _____ City _____ State/Zip _____ Troop # _____

Parent/Guardian _____ Home Phone () _____

Home Address _____ City _____ State/Zip _____

Business Address _____ Work Phone () _____

In Emergency Notify _____ Relationship _____

Address _____ Phone () _____

Name of Family Physician _____ Phone () _____

Family Medical/Hospital Insurance Carrier _____ Policy/Group # _____

PART I: Illness and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

- Ear Infection Bleeding/Clotting Disorders Hypertension Asthma Diabetes
 Heart Defect/Disease Musculoskeletal Disorders Seizures Other _____

Date of last health examination _____ Were any complicating medical problems noted? _____

Is participant currently under the care of a physician or psychologist? _____

Since last health exam, has participant had:

- a serious injury requiring medical attention?
- any prescribed or over-the-counter medication?
- treatment in a hospital or emergency room?
- any exposure to a contagious disease?
- an illness lasting more than 5 days?
- a surgical operation or fracture?
- any restrictions concerning physical activities?

Please explain any "yes" answers to the above questions, including dates: _____

PART II: Allergies

(Check those that apply and specify nature of allergic reaction.)

- Animals Hay Fever
 Pollen Food
 Medicines/Drugs Insect stings
 Plants Other _____

PART IV: My daughter has permission to take or use the following:

- Tylenol / Acetaminophen
 Advil / Ibuprofen
 Sudafed / decongestant
 Benadryl / antihistamine
 Pepto Bismol
 Tums / Antacid
 Robitussin / expectorant
 Swimmer's Ear / alcohol-vinegar solution

PART III: Other health conditions (Check those that apply.)

- Bed wetting Fainting
 Constipation Hearing impairment
 Menstrual cramps Sickle cell trait or disease
 Motion sickness Special dietary regimen
 Nosebleeds Wears glasses or contact lenses
 Sleep disturbances Other _____

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted. _____

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian _____ Date _____

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature of adult _____ Date _____