

Day Camp Adult Volunteer Application

This application must be filled out by all Day Camp Volunteers. Complete this application and return it to your Day Camp Registrar along with the adult health history form on the back of this page. You will find the Registrar's name and address after the camp description. Your Day Camp Director will notify you of date, time and place of Day Camp training. Thank you for your interest!

Name _____ E-mail _____

Phone (D) _____ (E) _____

Address _____ City _____ State/Zip _____

Which of the following skills would you be willing to share with girls? Please check the list below or add to this list. Indicate "I" for interest or "E" for experience in the categories below:

_____ Songs	_____ Lashing	_____ Clowning	_____ Performing Arts (list _____)
_____ Nature	_____ Hiking	_____ Cheerleading	_____ Creative Arts (list _____)
_____ First Aid	_____ Archery	_____ Orienteering/GPS	_____ Sports (list _____)
_____ Canoeing	_____ Games	_____ Dance	_____ Mime
_____ Crafts	_____ Knots	_____ Outdoor Cooking	_____ Sign Language

Are you CPR certified? Yes No Expiration Date _____

Are you First Aid certified? Yes No Expiration Date _____

Are you Troop Camp trained? Yes No Date of Training _____

Are you a registered Girl Scout? Yes No

Have you previously worked at a Day Camp? Yes No If yes, what GS grade level? _____

Please check which days you would be able to volunteer at Day Camp:
 All Week Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Please check/indicate first, second and third choice from listed options: LEVEL PREFERRED:
 _____ Tag _____ Boy Unit _____ GS Daisy _____ GS Brownie _____ GS Junior _____ GS Cadette _____ Anywhere there is a need

Do you have tagalongs (preschool or boys)?

Yes No (If yes, please list below.)

Name _____ Age _____

Day(s) Attending _____

Name _____ Age _____

Day(s) Attending _____

Do you have a daughter(s) attending camp?

Yes No (If yes, please list below.)

Name _____ Age _____

Day(s) Attending _____

Name _____ Age _____

Day(s) Attending _____

NOTE: Some camps do not have tag units available. Please check with Director.

Please make sure you complete a Health History Form for each tagalong.

In case of an emergency, contact: Name _____ Relationship _____

Phone (D) _____ (E) _____ E-mail _____

Address _____ City _____ State/Zip _____

Please List a Reference: Name _____ E-mail _____

Phone (D) _____ (E) _____ Relationship _____

Address _____ City _____ State/Zip _____

T-shirt size: S (34-36) M (38-40) L (42-44) XL (46) XXL (If applicable)

Name of Camp _____

PHOTO RELEASE: I agree to cooperate with all of the Girl Scouts of Southern Illinois's regulations. Further, Girl Scouts of Southern Illinois has my permission to use photographs or video tapes of myself for whatever purpose they see fit, including web site, with no claim whatsoever on my part.

Day Camp Volunteer's Signature _____ Date _____

COMPLETE THE HEALTH HISTORY FORM ON THE BACK OF THIS APPLICATION

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 Case of 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 _____