

# Day Camp Registration Form

- Health History Record (on back) must accompany this registration form.
- Mail with check to the Day Camp Registrar listed for your camp.
- If applying for a Campership, please complete request form and return it with this registration.
- **ADULT VOLUNTEERS ARE NEEDED!** If you are interested in volunteering, complete adult volunteer application form on and return it with this registration.

**Also complete the Health History on the back of this form.**

Camper's Name (Last Name, First Name & Middle Initial): \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

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

In case of an emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

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

Camper's Troop/Group # \_\_\_\_\_  Non Girl Scout Grade in Fall 2010: \_\_\_\_\_

**GS Grade Level:**  GS Daisy (K-1st)  GS Brownie (2nd-3rd)  GS Junior (4th-5th)  GS Cadette (6th-8th)  Non Girl Scout

PAT (Program Aide in Training): 7th grade & up, Fall 2010 • Offered at Bethalto, Collinsville & Columbia Day Camps only

PA (Program Aide): 7th grade & up, Fall 2010 • Must have completed Program Aide Training. Date of Training: \_\_\_\_\_

Volunteering to work at camp: check level  Tag (preschool)  GS Daisy  GS Brownie  GS Junior

**The camper's racial background is:** (please check as many as apply)  American Indian or Alaskan Native  Asian

Black or African American  Hawaiian or Pacific Islander  White  Other (specify \_\_\_\_\_)

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

Name of Day Camp: \_\_\_\_\_

Has child attended Day Camp before?: \_\_\_\_\_ If yes, when and where?: \_\_\_\_\_

Has child earned a Day Camp Progression patch? If yes, what was the last patch earned?: \_\_\_\_\_

If applicable, T-shirt size:

Youth:  S (6-8)  M (10-12)  L (14-16)

Adult:  S (34-36)  M (38-40)  L (42-44)  XL (46)

**Note: Some Day Camps do not offer t-shirts.**

Name of buddy your child would like to be with: \_\_\_\_\_ **Only include one buddy.**

Check here if camper has any special needs. (Physical restrictions, food allergies, diet, etc.). Please list: \_\_\_\_\_

• Day Camp Fee: \$ \_\_\_\_\_

• Non Girl Scout fee includes \$12 membership dues into GSUSA. **All Campers must be registered Girl Scouts.**

• **Please include cost of overnight, if applicable.**

• *If Girl Scout Cadettes - Ambassadors are volunteering to work as Day Camp PA, check with Day Camp Director for fee information.*

*Fees are sometimes reduced/waived for girl volunteers.*

## Mail registration form with check payable to: (Refer to specific Day Camp information)

Please check if requesting:  Campership (Include the Campership Application with your registration form.)

**Girl Scout/Non Girl Scout Consent:** I give my consent to have my daughter/ward \_\_\_\_\_ be a Girl Scout member, attend camp and participate in all phases of the activities. I/we agree to cooperate with all of the Girl Scouts of Southern Illinois regulations. Further, Girl Scouts of Southern Illinois has my/our permission to use photographs or videotapes of my/our daughter/ward for whatever purpose they see fit, including web site, with no claim whatsoever on my/our part.

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 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

- |   |  |                                       |                                      |                                   |
|---|--|---------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ear Infection        | <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Musculoskeletal Disorders   | <input type="checkbox"/> Seizures     | <input type="checkbox"/> 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?  | • an illness lasting more than 5 days?             |
| • any prescribed or over-the-counter medication? | • a surgical operation or fracture?                |
| • treatment in a hospital or emergency room?     | • any restrictions concerning physical activities? |
| • any exposure to a contagious disease?          |  |

Please explain any "yes" answers to the above questions including dates: \_\_\_\_\_

### PART II: Allergies

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

- |  |  |
|--|--|
| <input type="checkbox"/> Animals         | <input type="checkbox"/> Hay Fever     |
| <input type="checkbox"/> Pollen          | <input type="checkbox"/> Food          |
| <input type="checkbox"/> Medicines/Drugs | <input type="checkbox"/> Insect stings |
| <input type="checkbox"/> Plants          | <input type="checkbox"/> Other _____   |

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

- |   |
|---|
| <input type="checkbox"/> Tylenol / Acetaminophen                  |
| <input type="checkbox"/> Advil / Ibuprofen                        |
| <input type="checkbox"/> Sudafed / decongestant                   |
| <input type="checkbox"/> Benadryl / antihistamine                 |
| <input type="checkbox"/> Pepto Bismol                             |
| <input type="checkbox"/> Tums / Antacid                           |
| <input type="checkbox"/> Robitussin / expectorant                 |
| <input type="checkbox"/> Swimmer's Ear / alcohol-vinegar solution |

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

- |   |  |
|---|--|
| <input type="checkbox"/> Bed wetting        | <input type="checkbox"/> Fainting                        |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Hearing impairment              |
| <input type="checkbox"/> Menstrual cramps   | <input type="checkbox"/> Sickle cell trait or disease    |
| <input type="checkbox"/> Motion sickness    | <input type="checkbox"/> Special dietary regimen         |
| <input type="checkbox"/> Nosebleeds         | <input type="checkbox"/> Wears glasses or contact lenses |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> 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 \_\_\_\_\_