

Use this form to provide one-time permission for participation in: 1) A single troop/group meeting, event, activity, or 2) Any [approved high risk activity](#), or 3) Approved [national and international travel](#). **A physical copy of this signed form must be carried by the troop/group leader.**

Activity Information					
Activity				Girl Scout Troop/Group #	
Location					
Departure Place	Time	Date	Return Place	Time	Date
Participant Information					
Girl Scout First Name		Girl Scout Last Name		Date of Birth	
Address					
City			State		ZIP
Parent/Guardian Information					
Parent/Guardian First Name			Parent/Guardian Last Name		
Address (if different from participant's)					
City			State		ZIP
Phone #1			Phone #2		
Email Address					
Emergency Contacts					
In the event that a parent/guardian cannot be reached in an emergency, the following individuals will be contacted:					
Name		Phone(s)		Relationship to Child	
Name		Phone(s)		Relationship to Child	
Accommodations					
My child requires the following physical, mental, psychological, or other accommodations (attach additional sheets as needed): _____					

This signed permission form must be retained by the troop/group leader.

Over-the-Counter Medication

In the event that administration of over-the-counter (OTC) medication is recommended by your troop or event first aider, **check the boxes below to indicate which types of OTC medications your child is authorized to receive.** Unchecked medications **will not** be administered.

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen (Tylenol or generic) | <input type="checkbox"/> Antibiotic ointment |
| <input type="checkbox"/> OTC Antacid (Tums) | <input type="checkbox"/> Non-medicated cough drops |
| <input type="checkbox"/> Ibuprofen (Advil or generic) | <input type="checkbox"/> Sunscreen (without PABA, minimum SPF 30) |
| <input type="checkbox"/> Calamine lotion | <input type="checkbox"/> Insect repellent (may contain up to 15% DEET) |
| <input type="checkbox"/> Diphenhydramine (Benadryl or generic) | <input type="checkbox"/> Hydrocortisone |

Health History

Name of Physician

Phone

Allergies (check all that apply):

- ☐ Animals _____
- ☐ Food _____
- ☐ Peanut _____
- ☐ Hay fever _____
- ☐ Insect stings _____
- ☐ Medicine/drugs _____
- ☐ Plants _____
- ☐ Pollen _____
- ☐ Other (specify) _____

Chronic or Recurring Illness (check all that apply):

- ☐ Heart defect/disease _____
- ☐ Seizures _____
- ☐ Bleeding/clotting _____
- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Other (specify) _____

List any restrictions on physical activities: _____

List any medications taken on a daily basis, including over-the-counter medications: _____

List any other relevant health concerns: _____

Parent Permission

The named **participant** has my permission to participate in this activity. Participant is in good physical condition and has my permission to receive first aid and to receive emergency treatment from a licensed physician. It is understood that all reasonable efforts will be made to contact me in case of emergency. I further release Girl Scouts of Oregon and Southwest Washington from any liability or damages, including any claim for injuries incurred by my child as a result of participation in this Girl Scout activity.

☐ My Girl Scout may NOT be photographed or videographed for Girl Scout publicity purposes.

As the parent/legal guardian of the named participant, my signature affirms that I have read and understand this permission form. I may change or revoke any aspect of this agreement at any time by submitting my request, in writing, to the troop/group leader.

Signature of Parent/Guardian

Date