



Annual Permission Slip & Health History

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Complete this form at registration time. This form will be retained by the troop/group leader.

October 1, 20____ to September 30, 20____

Name		Troop	Date of Birth
Street Address	City	State	ZIP Code

Permission for Trips Yes No* Initialed_____

My child has permission to travel to, attend and participate in troop and council-sponsored activities that are 1.) Three (3) nights or less, and 2.) Not considered high-risk activities as outlined by Girl Scouts. Leaders will be notifying parents/guardians of activities planned. (*By checking "No", I am requesting to sign individual permission slips for each activity.)

Permission to Use Photographs Yes No Initialed_____

I hereby consent that the videotapes, photographs, motion pictures, electronic images and/or audio recordings of my child may be used by Girl Scouts for public relations and publicity purposes. (I understand that her name and residence will not be used for publicity purposes.)

Permission for Emergency Medical Treatment Yes No Initialed _____

In the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Oregon and Southwest Washington to seek treatment for my child and/or dependent minor by a licensed physician or dentist. I know of no reason(s) why my child may not participate in prescribed activities except as noted on the health history form.

If permission for emergency medical treatment is not given, please prepare a signed statement providing the reason, a release of liability, and alternate instructions and attach to this form.

Special Accommodations

My child requires the following special accommodations: _____
(write "none" if there are none)

Health History

This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me. In case of illness or injury, I/we give permission for her to receive first aid, and to receive emergency treatment from a licensed physician, emergency medical services, or other health care professional. It is understood that all reasonable efforts will be made to contact the parent or guardian.

Check all that apply:

- | | |
|--|--|
| <p>Allergies:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Animals_____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Peanut _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect Stings _____ <input type="checkbox"/> Medicine/Drugs _____ <input type="checkbox"/> Plants _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____ | <p>Chronic or Recurring Illness:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Defect/Disease _____ <input type="checkbox"/> Seizures _____ <input type="checkbox"/> Bleeding/Clotting _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Other (specify) _____ <p>Had any Restrictions Concerning:
Physical Activities? _____
Please describe any conditions: _____</p> |
|--|--|

Emergency Contact			
Name	Telephone(s)	Relationship to Child	
Name	Telephone(s)	Relationship to Child	
Parent Agreement			
I have read and understand this annual 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.			
Printed Name of Parent/Guardian	Signature of Parent/Guardian		Date
Street Address (if different from girl's)	City/State/ZIP	E-mail Address	
Home Telephone	Work Telephone	Mobile Telephone	Other Telephone