| Membership Year |
|---|
| ________/________ |
| Current Grade in School |
| ____________ |

# PARENT CONSENT FORM

Girl's name: First ______________________ Middle ______________ Last ____________________________

Address ____________________________________ City ___________________ State _____ Zip __________

1. I/we give permission to certified adults to administer first aid to my daughter or seek and have aid given from a physician or hospital if the situation requires. It is my understanding that my daughter is covered by Girl Scout Accident Insurance. I do not hold the troop, its' leaders, or the Girl Scouts of Gulfcoast Florida, Inc. at fault in case of accident.

2. I/We authorize the doctor or hospital personnel to provide emergency medical treatment and or anesthesia to be administered in my/our absence. This authorization includes, but is not limited to, any emergency treatment and/or surgical procedure(s) deemed necessary by the qualified personnel. I/we understand, that by law, a health facility cannot provide needed treatment unless the parent/guardian is with the child or provides appropriate authorization.

**GIRL HEALTH HISTORY RECORD This health history is to be completed and signed by the parents/guardians of girls.**

Name of physician ______________________________________ Phone _____________________________

Family medical/hospital carrier ______________________________ Policy or group # ______________________

Date of last health examination ________________________

Were there any complicating medical problems noted in last health examination? ___________________________

***Please note any additional information regarding girl's behavioral, physical, or emotional health and attach to this form.***

**HEALTH HISTORY** (Please check all that apply)

| Diseases | Allergies | Chronic or Recurring Illness | My daughter has permission to take or use the following: |
|---|---|---|---|
| ❑ Chicken Pox | ❑ Animals__________ | ❑ Asthma | ❑ Tylenol/Acetaminophen |
| ❑ German Measles | ❑ Food __________ | ❑ Bleeding disorders | ❑ Advil/Ibuprofen |
| ❑ Kidney disorders | ❑ Hay Fever__________ | ❑ Diabetes | ❑ Sudafed/decongestant |
| ❑ Measles | ❑ Insect stings __________ | ❑ Ear infections | ❑ Benadryl/antihistamine |
| ❑ Mumps | ❑ Medicine/drugs__________ | ❑ Heart defect/disease | ❑ Pepto Bismol |
| ❑ Rheumatic Fever | __________ | ❑ Hypertension | ❑ Tums/antacid |
| ❑ Tuberculosis | ❑ Plants __________ | ❑ Hypotension | ❑ Insect repellent |
| ❑ Other (specify) | ❑ Pollen __________ | ❑ Hypoglycemia | ❑ Hydrocortisone/anti-itch |
| __________ | ❑ Other (specify) | ❑ Musculoskeletal disorders | ❑ Gold Bond/anti-heat rash |
| | __________ | ❑ Seizures | ❑ Sunscreen |
| | | ❑ Sinusitis | ❑ Neosporin/triple antibiotic |
| | | ❑ Other (specify) | ❑ Sting stick for insect bites |
| | | __________ | ❑ Throat lozenges |
| | | | ❑ Ear drops |

| **SPECIAL NEEDS** (check all that apply): | | **LIST ANY MEDICATIONS - DOSAGE AND FREQUENCY:** |
|---|---|---|
| ❑ Fainting | ❑ Sleep disturbances | |
| ❑ Bed wetting | ❑ Menstrual cramps | |
| ❑ Constipation | ❑ Nosebleeds | |
| ❑ Emotional disturbances | ❑ Hearing Impairment | |
| ❑ Sickle cell trait or disease | ❑ Special dietary regimen | |
| ❑ Wears glasses or contact lenses | ❑ Motion sickness | |
| ❑ Other ______________________ | | |
| Has your daughter started her menstrual cycle? Yes ❑ No ❑ | | |

Girl Scouts of Gulfcoast Florida, Inc.

# PARENT CONSENT FORM

The following person(s) is AUTHORIZED to pick up my child:

Name ______________________________________________ Relationship ______________________________________

The following person(s) is **FORBIDDEN** to pick up my child:

Name ______________________________________________ Relationship ______________________________________

**EMERGENCY CONTACT INFORMATION**

In case of emergency notify: ________________________________________ Relationship ____________________________

Home phone ___________________________________

Work phone ___________________________________

Cell phone ___________________________________

Address ____________________________________________ City __________________ State ______ Zip ____________

**PLEASE INITIAL ALL BELOW**

_____ **My daughter has permission to carry and administer her own medication such as: bronchial inhalers; epipen; or diabetes medication.**

_____ **My daughter fully understands that she is not allowed to give any medications that she has with her to any other person and will inform the person in charge of first aid when she has taken any of this medication herself.**

_____ **This health history is complete and accurate to the best of my knowledge. I affirm that my child's immunizations are up to date.**

_____ **This consent form serves as permission for my daughter to participate in all Girl Scout activities unless otherwise noted by me in writing.**

Signature of parent/guardian ___________________________________________________ Date ______________________

**Troop leaders, please keep a copy of the Parent Consent Form and Girl Registration Form in your records. Forms must accompany you when you attend meetings, field trips, or a council-sponsored program event.**

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**www.gsgcf.org**