GIRL SCOUTS OF THE JERSEY SHORE

PARENTAL PERMISSION SLIP

My daughter _____

has permission to participate in the following activity

Robotics Camp - Program Activity Center July 21-22, 2018

(Date and Location of Activity)

Date of her last tetanus shot_____. She is allergic to:

_____

_____

I have noted her physical limitations on the back of this form.

During the activity, I may be reached at:

Address: _____

Home Phone #_____

Cell Phone # _____

If I cannot be reached in the event of an emergency, the following

Person is authorized to act on my behalf:

Name and
Address_____

Relation to participant_____

Telephone #_____

Parent/Guardian Name_____

_____

Parent / Guardian Signature

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242 Adelphia Road
Farmingdale, NJ 07727

1405 Old Freehold Road
Toms River, NJ 08753

Girl Scouts of the Jersey Shore

STANDARD HEALTH HISTORY/PERMISSION SLIP

To be filled in by parent/guardian.

Information is confidential and only provided to leader or chaperone in case of emergency.

_____ (____)_____
Girl's Name (Last, First, Initial) Home Phone # Birth date Age

_____ (____)_____
Parent/Guardian's Name Daytime Phone #

_____
Address Town State Zip

_____(____)_____
In Emergency Notify Address Daytime Phone #

_____
Medical Insurance ID#

_____, (____)_____
Name of Pediatrician/Doctor Phone

Date of last physical exam: _____

Health History: (check those that apply)

Diseases	***Allergies***	***Chronic or Recurring Illness***
□ Chicken Pox	□ Animals	□ Ear Infections
□ Measles	□ Pollen	□ Heart Defect/Disease
□ German Measles	□ Hay Fever	□ Seizures – medication*
□ Mumps	□ Insect Stings	□ Bleeding Disorders
	□ Medicine/Drugs	□ Asthma – inhaler*
	□ Plants	□ Hypertension
	□ Food *	□ Diabetes
	□ Other* (Specify)	□ Musculoskeletal Disorders
	_____	□ ADD
	_____	□ Other* (Specify)_____
	_____	_____

Authorization for treatment: In the case of an emergency, I hereby give permission to the physician selected by the leader to secure and administer treatment, including hospitalization for my child as named above.

Parent/Guardian signature_____Date:_____

Continued on back

Please describe conditions and give dates:

Operations or serious injuries_____

Hospitalizations_____

Other diseases/disabilities_____

Does your child take any medication regularly? _____

If so, name of medication_____

for what condition? _____

Comments where applicable:

Fainting_____

Menses_____

Constipation_____

Nosebleeds_____

Emotional disturbances_____

Injuries_____

Other_____

Special medical or dietary regimen to be followed (be specific) _____

_____

My child has permission to take Tylenol - Yes_____ No_____

Number of tablets_____ Child or Adult_____

Tylenol will be given in case of fever or headache. Parent will be notified if given.

Are there any additional concerns, medical or otherwise, you wish to bring to our attention? _____

_____

_____

This health history is correct and my child has permission to engage in all prescribed activities, except as noted by me.

Parent/Guardian signature _____ Date: _____

If no changes from prior year: ***Parent/Guardian initial _____ Date: _____***

Parent/Guardian initial _____ Date: _____

Parent/Guardian initial _____ Date: _____