



CRESCENTA VALLEY GLENDALE SERVICE UNIT  
TWILIGHT CAMP APPLICATION

2010

Last-name: \_\_\_\_\_ First-name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you a registered Girl Scout? Yes \_\_\_\_\_ No \_\_\_\_\_ Troop # \_\_\_\_\_ Leader's Name: \_\_\_\_\_

Camper's Email: \_\_\_\_\_ Age: \_\_\_\_\_ School \_\_\_\_\_ Grade in Fall: \_\_\_\_\_

In the Fall, Camper will be a... Brownie \_\_\_\_\_ Junior \_\_\_\_\_ Cadette \_\_\_\_\_

Youth T-shirt Size: S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ Adult T-shirt Size: S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Siblings in Camp: Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_ Age of siblings: \_\_\_\_\_

Persons to notify in case of emergency if parents cannot be reached

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**AUTHORIZATION FOR PICK UP – Please list below anyone authorized to pick-up your child during the week of Twilight Camp, from June 21, 2010 to June 24, 2010**

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

4. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

5. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

6. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

7. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

8. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**UNDER NO CIRCUMSTANCES SHOULD MY CHILD BE RELEASED TO:**

**Please list below anyone NOT authorized to pick-up your child**

1. Name: \_\_\_\_\_

2. Name: \_\_\_\_\_

**Please tell us about your child (include any physical/emotional condition about which we should be aware):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# HEALTH HISTORY INFORMATION

This form must be completed by parent(s) of each registering Girl Scout (please print).

Girl's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Group/Troop # \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_

## Girl Health History Information

Medical Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Is your daughter's immunization record up-to-date?  Yes  No Date of last tetanus shot: \_\_\_\_\_  
(Month-Day-Year)

- Check all that apply:
- Motion Sickness
  - Nosebleeds
  - Sleep Disturbances
  - Fainting
  - Bed Wetting
  - Hearing impairment
  - Wears glasses or contact lenses
  - Special dietary regimen
  - Constipation
  - ADD/ADHD
  - Emotional Disturbances
  - Other \_\_\_\_\_

Please list any allergies (penicillin, food, insects, etc.): \_\_\_\_\_

Please list any additional medical condition of which the leader should be aware (i.e. chronic condition, disabilities, behavioral problems, medications, etc.): \_\_\_\_\_

**NOTE: All medication must be in original container, with girl's name, dosage and frequency clearly printed on the label.**

## Council Policies and Procedures (check one and sign below:)

- The undersigned do hereby authorize the officers, leaders or agents of Girl Scouts of Greater Los Angeles, to consent to any x-ray examination, anesthetic, medical or surgical treatment and hospital care to be rendered to said minor under the general or special supervision and upon the advice of a physician or surgeon licensed under the provisions of the Medical Practice Act, or to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act. It is further understood that permission is hereby granted to the officers, leaders or agents of Girl Scouts of Greater Los Angeles to obtain and administer such medical aid or assistance as might, in their judgment, be required for the immediate care of your daughter. In the event of such help, Girl Scouts of Greater Los Angeles, its officers, leaders and agents will not be held liable for any first aid treatment or hospital care rendered drugs, medicine or surgical procedures performed pursuant to this consent. This consent supersedes all prior authorization.
- If you do not consent to the care or treatment set forth herein, describe in detail what is or is not allowed/permitted

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_