

Girl Scouts of Rhode Island, Inc.

1. Name _____ Age _____ Birth date ____/____/____ Grade _____

Permanent Address _____
(Street) (City/Town) (State) (Zip)

Child is under the custodial care of (check one) Both parents Mother only Father only Other

Parent/Guardian Name _____ Home phone(____) _____ Work Phone (____) _____ Cell Phone (____) _____

2. Emergency Information

Other than the phones listed above, where can you be reached during the Girl Scout Activity? _____

Parent/Guardians: If you cannot be reached in case of an emergency, please list the name of a friend or relative who will be able to help us locate you or who can come and pick up your child.

Name _____ Relationship to Scout _____
Daytime Phone (____) _____ Evening Phone (____) _____ Other Phone (____) _____

3. Medical Information (Mandatory)

Health Insurance Company name _____ Policy # _____ OR No Insurance

➤ Does your child have any allergies and/or dietary restrictions (check one) Yes No

If yes, explain _____

➤ Date of last tetanus shot _____ Are immunizations up-to-date? Yes No

➤ Does your child need to take medication during this Girl Scout Activity? Yes No

If YES, please complete a separate **Permission to Dispense Medication Form** and turn it into the leader.

➤ My child carries and may administer an epi-pen, inhaler or diabetes medication Yes No

➤ I give my permission to give acetaminophen (Tylenol) Yes No & Tums for stomach distress Yes No as deemed necessary.

Authorization for Treatment: In the event I cannot be reached in an emergency situation, I hereby give permission to the physician selected by the Troop Leader to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent/Guardian _____ Date _____