



Girl Scouts – North Carolina Coastal Pines  
 P.O. Box 91649, Raleigh, NC 27675-1649  
 (800) 284-4475 or (919) 782-3021



**PARENT/GUARDIAN PERMISSION FOR TROOP OUTINGS**

**Please complete this form and return to your daughter's troop leader. Permission(s) and release information is needed before your daughter can participate in Girl Scout troop activities. Please print legibly.**

Girl's Name \_\_\_\_\_ Troop# \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_

Parent's/Guardian's Phone # ( ) - \_\_\_\_\_ Cell Phone # ( ) - \_\_\_\_\_

Emergency Contact Name/phone # \_\_\_\_\_

(\*Someone other than the parent/guardian who we can call in an emergency.)

This permission is required for all Troop activities away from the meeting place. My daughter/ward has my permission to participate in any troop/group-sanctioned or Girl Scouts-North Carolina Coastal Pines-sanctioned trip, event and activities during the 20\_\_-20\_\_ membership year. I understand that I will receive information giving specific departure and arrival times, planned activities, contact persons, and any other pertinent information prior to any trip or event.

I agree that pictures or videos of my daughter/ward may be used to promote the Girl Scout program.  Yes  No

GSUSA provides activity accident insurance as secondary coverage to the family's own insurance coverage.

**Custody Type:** (select one)  Both Parents  Mother only  Father only  Other \_\_\_\_\_

My child may be picked up by: \_\_\_\_\_

\_\_\_\_\_  
 \*Signature of Parent or Legal Guardian

\_\_\_\_\_  
 Date/Updated Date

**HEALTH HISTORY FOR GIRLS AND/OR ADULTS**

**(Adult participants please fill out the Health History portion only.)**

Name of Participant \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name of Participant's Physician \_\_\_\_\_ Telephone # ( ) - \_\_\_\_\_

Date of last physical \_\_\_\_\_

Family Medical/Hospital Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Is your daughter currently under a physician's care for a medical problem? If so, explain: \_\_\_\_\_

List any allergies your daughter/ward may have (i.e., Pollen, insect stings, etc.) \_\_\_\_\_

List any other health conditions (i.e., nosebleed, emotional disturbances, menstrual cramps, motion sickness, etc.). Please explain. \_\_\_\_\_

<b>Immunization</b>		This information is confidential and will only be shared with persons who have a need to know in order to protect the health and safety of the participant.
Year Primary Series Completed	Year of Last Booster	
D.P.T. (Diphtheria, Tetanus, Whooping Cough)	_____	

**Authorization for Treatment:** I hereby give permission to the medical personnel selected by the Girl Scout adult in charge to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child/me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Girl Scout adult in charge to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for use off-site.

\_\_\_\_\_  
 Signature of parent/guardian of minor or adult participant

\_\_\_\_\_  
 Date/ Updated Date

