



2010 CAMP CADDELL DAY CAMP REGISTRATION

Please complete this form (both sides) and return to Tracy Cheatham with camp fee.

Camper's Name _____ Birth date _____

Address _____ Age (at camp time) _____

_____ Phone # _____

Troop # _____ Grade in fall _____ Level in Girl Scouts this Fall: **2nd year D B J C S A**
Grade Level 1st 2nd-3rd 4th-5th 6th-8th 9th-10th 11th-12th

Parent or Guardian _____ Phone # _____ Email _____

Emergency Contact _____ Phone # _____

Address _____ Relationship to Camper _____

We encourage you voluntarily to provide the following information on racial background and ethnicity. This information will be used by Girl Scouts-North Carolina Coastal Pines to help improve outreach efforts and advance the Girl Scout Movement.

The registrant's racial background is: (please check as many as apply)
 ___ American Indian or Alaskan Native ___ Asian ___ Black or African American
 ___ Hawaiian or Pacific Islander ___ White ___ Other (specify _____)

The registrant's ethnic background is: (please check one)
 ___ Hispanic or Latina ___ Not Hispanic or Latina

T-shirt Sizes: Adult ___S ___M ___L ___XL ___XXL ___XXXL
 Child ___M ___L

_____ Girl Scout Camper — \$60
 _____ Non-Girl Scouts — \$72 (\$12 will be used for Girl Scout Membership)
 _____ Overnight fee — \$5 (Must be 4th grade and up & have 1 overnight experience with troop)
 _____ Staff Child — \$30.00 (Must volunteer at least 4 days)
 _____ Cadette or Senior Helper — \$30.00

Total Enclosed

Financial Assistance Requested (mail to Tracey Cheatham with campership form and \$5.00)

Buddy Preference (if possible) _____

**All girls from one troop will not be together.*

Adult Help: **Yes, I can help** ___ **5 days** ___ **Wednesday overnight** ___ I have a child who will need to be in the Little Dears Unit ___ # and ages: _____

Other (list): ___ I will be lifeguard ___ I have camping skills, knots, etc. ___ Transportation
 ___ Craft Experience ___ I have Red Cross First Aid ___ I can be Camp Nurse

TO PARENT OR GUARDIAN — This application must have your signature before camper can be accepted. My daughter has my permission to participate in Camp Caddell Day Camp. Pictures and/or videos of my daughter(s) taken at camp may be used to promote Girl Scout Programs. I give my permission for my daughter to become a Girl Scout if she is not all ready one.

Signature of Parent or Guardian _____ Date _____

***** Remember to complete the Health History and Medication form included with this application. *****



MEDICATIONS FOR TRIPS/EVENTS/DAY CAMPS

This form must be completed for each event or trip at which your daughter is to be given medication. Please read this form carefully and fill out the required information for your daughter's safety and comfort.

Name of trip/event/camp Lee County Girl Scout Day Camp Date of trip/event/camp June 14 – 18, 2010

Person in charge of trip/event/camp Sandie Lemons

Written parental consent is required before a minor (under 18) Girl Scout may be given any medication or treatment of any kind. During trips or at events, girls may need medication for ailments such as headaches, stomachaches, diarrhea, or a low-grade fever. They might need sunscreen, insect repellent or chapstick. You **MUST** send any over the counter medication your daughter may need in the original bottle/package (INCLUDING ASPIRIN, TYLENOL, ETC.). Prescription drugs must be in the original bottle/ package with the physician's instructions for administering them. Put all drugs in a ziploc bag and label it with your daughter's name. Medication will be available from the adult in charge of first aid and can be given as specified by instructions on the label for prescription drugs or by written instructions from parents/guardians for over the counter drugs. Complete the middle part of this form with instructions.

Girls may keep asthma sprays, epi-pens, insect repellent, sunscreen, or chapstick with them if they know how to use them. All other medication must be turned in to the adult in charge of first aid, unless we have a note signed by a physician stating that a girl must keep a certain medication with her.

It is the responsibility of the girl/parent to make sure all medication is picked up at the end of the trip/event/camp.

List all over the counter and/or prescription medication that your daughter will have at this trip/event/camp. **Give exact instructions for administering over-the-counter medications. We cannot administer over-the-counter medication without written instructions.**

MEDICATION	INSTRUCTIONS

Medication/chemical treatments recommended by the American Red Cross:

The following items are recommended by the American Red Cross as the appropriate treatment for these conditions. **Initial each treatment you want your daughter to receive if needed.** These medications should be available in trip/event/camp first aid kits. **No other medication is available unless sent with your daughter.**

- | | |
|---|---|
| _____ Poisoning | Syrup of Ipecac, Activated Charcoal - administered as directed by the Carolina Poison Control Center, 1-800-848-6946. |
| _____ Small wounds, cuts, animal or tick bite, minor burn | Antibiotic ointment |
| _____ Poison Ivy | Topical antihistamine such as Caladryl or hydrocortisone cream |
| _____ Marine life stings | Baking soda and salt water |
| _____ Sunburn | Aloe gel |
| _____ Insect bites | Topical antihistamine |

I give my permission for my daughter/ward _____ to take the medications listed above and, if needed, to have any of the treatments I have initialed.

Parent/Guardian signature _____ Date _____



2010 DAY CAMP HEALTH HISTORY

NAME _____ Birth date _____
 Last First MI Month/Day/Year

1. Emergency Contact (other than parents): Name _____ Relation to participant _____
 Home Phone # () _____ Cell Phone # () _____ Business Phone # () _____

2. Has, has had, or is subject to: (Circle and give details)

<input type="checkbox"/> Allergies: Foods, medicines, insects, plants, pollen, animals. Explain: _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart defect/disease	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Bleeding/clotting disorders	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Cancer, leukemia	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Contact lens
<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Sickle cell trait or disease	<input type="checkbox"/> Glasses
<input type="checkbox"/> Emotional disturbances	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Dental appliance
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> German Measles	<input type="checkbox"/> Mumps	
<input type="checkbox"/> Measles	<input type="checkbox"/> Frequent tonsillitis	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Convulsions			

Any other condition that may require special care, medication, or diet.
 Explain: _____

3. Immunization History

<u>Date</u>	<u>Vaccine</u>
_____	_____
	DTP

Do you carry family medical/hospital insurance? Yes No

If so, indicate: Carrier _____ Policy or Group # _____

4. Date of camper's last health examination: _____
 Were any complicating medical problems noted in examination? _____
 Is the camper currently under a physician's care for a medical problem? (Describe) _____

 Is the camper currently taking medication on a regular basis? (What and for what) _____

 Name of family physician _____ Phone _____

5. Is the camper restricted from participating in any specific activities? (What?) _____

6. All medications: must have parent permission, signed and dated, with specific dosage instructions; must be in original container; must be turned in to Adult First-Aider. If participants must keep any medications with them, notify Adult First-Aider in writing.

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 AUTHORIZATION FOR TREATMENT. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me.

I hereby give permission to the medical personnel selected by the Girl Scout adult in charge to order x-rays, routine tests and 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 \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my Girl Scout program activities, as noted on this form.

Signature of minor or adult participant \_\_\_\_\_ Date \_\_\_\_\_