Girl Scouts of Central and Western Massachusetts, Inc.
413-584-2602· gscwm.org

Worcester Leadership Center
115 Century Drive
Worcester MA, 01606

Holyoke Leadership Center
301 Kelly Way
Holyoke MA. 01040
Fax: 413-536-1383

Adult Authorization and Medical Information

Please read the following carefully. Girl Scouts of Central and Western Massachusetts has created this form to ensure you have a safe and enjoyable experience as a Girl Scout volunteer. It is your responsibility to inform the council, troop leader or other appropriate volunteer (i.e. service unit manager) of any health or physical limitations you may have that may affect your participation in a Girl Scouts activities.

Fill out and return this form to your child's leader, Girl Scout event coordinator or council staff as is relevant.

Troop #:_____ Name:_____ Birth date:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ E-mail:_____

Authorizations

I as the individual named above give my permission for:

☐Yes ☐No 2. When participating in Girl Scout activities, the registrant may be photographed for print, videotaped, or electronically imaged. Images may be used in promotional materials, news releases, and other published formats for either the local Girl Scout council (GSCWM) or Girl Scouts of the USA. The images will be the sole property of either the Girl Scout council (GSCWM) or Girl Scouts of the USA.

☐Yes ☐No 3. Me to receive medical treatment by a leader, first aider, EMT, nurse, doctor or hospital if necessary. It is understood that the adult in charge or her designee will attempt to contact my emergency contact.*

If you check "No," please sign the following: I have objections to receiving medical treatment.

Signature:_____

* In the case of a medical emergency, I hereby give permission to the physician selected by the adult in charge, to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for me. Girl Scout authorities may take such emergency measures as deemed appropriate, including transportation, and shall notify my emergency contact soon as possible. If I need medical treatment, I authorize the holder of my medical information (i.e., doctor, hospital) to release to the health/accident insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Emergency Contact Information

Emergency Contact	*Address*	*Phone (include home & cell)*
Physician to Contact	*Address*	*Phone (include home & cell)*

Health History

Illnesses and Injuries (Check all that apply):

☐ Asthma ☐ Heart Disease ☐ Diabetes ☐ Seizures ☐ Other (specify): _____

Allergies (Check those that apply and specify nature of allergic reaction):

☐ Animals: _____ ☐ Insect Stings: _____
☐ Food: _____ ☐ Medicines/Drugs: _____
☐ Other: _____

Other Health Conditions (Check those that apply):

☐ Glasses ☐ Contact Lenses ☐ Deaf or Hard of Hearing ☐ Nosebleeds ☐ Motion Sickness
☐ Dental Appliances ☐ Other (specify): _____

Date of Last Tetanus Shot: _____ Date of Last Health Examination: _____

Please check those statements that apply since your last health exam (explain checked answers below):

☐ A serious injury requiring medical attention ☐ An illness lasting longer than one week
☐ A surgical operation or fracture ☐ Treatment in a hospital as inpatient or emergency room

Please Explain (include dates): _____

Are you restricted from participating in any physical activities? ☐ No ☐ Yes *Explain:* _____

_____

Please provide any other information about you which might be needed in an emergency: _____

_____

Form Updated:

Date: _____ Signature: _____