# KEYS TO LEADERSHIP

## National Girl Scout Conference on Inclusion

***Registration also available online at http://www.gscnc.org/Keys_to_Leadership.html.***

**Girl's Name**: ______________________________________________

Address: ______________________________________________

City:______________________________ State: _______ ZIP Code: ______________

E-mail: ______________________________________________

Grade: ____________________ D.O.B.: ______________ Age: ____________

Current school: ______________________ Location: ☐ MD ☐ DC ☐ VA

Currently registered Girl Scout? ☐ No ☐ Yes, Troop #______________________

Mother/Guardian: __________________________ E-mail:____________________

Phone: Day ________________Evening: __________Cell: ________________

Father/Guardian: __________________________ E-mail:____________________

Phone: Day ________________Evening: ______________Cell: ________________

The child is in the custody of:

☐ Both parents ☐ Mother ☐ Father ☐ Other ______________________________

**Must have information for emergency contact** if parent(s) cannot be reached (please print clearly):

Name/Relationship:______________________________ Phone: __________

Name/Relationship:______________________________ Phone: __________

**Parent/Guardian Permission Statements**

The health history on the reverse side is correct so far as I know, and the person herein described has my permission to participate in all prescribed camp activities as noted. If she appears to be ill, I will not send her to the program.

**EMERGENCY AUTHORIZATION:** In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director or her/his designee to hospitalize, to secure proper treatment, and/or order injection and/or anesthesia and/or surgery for my child as named above.

The council may use photographs in which my child appears to promote Girl Scouting:

☐Yes ☐No

I understand my daughter will become a registered member of Girl Scouts of the USA through participation in this program.

Signature: ________________________________________ Date: __________

***The signature of the parent or guardian is required for participation.**

*Please fill out the reverse side*

## HEALTH HISTORY

To be completed in detail for all participants. Please use additional sheet to describe symptoms of allergies and details of health concerns or restrictions.

**Girl's Name**: ______________________________________________

**Allergies**

☐ Insect Bites/Stings ☐ Hay Fever ☐ Poison Ivy/Oak ☐ Other ____________________

**Food Allergies and Dietary Restrictions**

☐ Vegetarian ☐ Vegan ☐ Kosher ☐ Halal ☐ Food Allergy____________________

☐ Other______________________________________________

**Health Concerns**

☐ Ear Infections ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Skin Conditions

☐ Other______________________________________________

**Other Needs**

☐ Cognitive Disability ☐ Learning Disability ☐ Physical Disability ☐ Visual Disability

☐ Deaf/Hard of Hearing ☐ Emotional/Behavioral Disability ☐ Other____________________

If your child has a disability, what accommodations does she need to actively participate in the conference sessions (larger print, sign-language interpreter, language interpreter, etc.)?

______________________________________________

______________________________________________

Operations or serious injuries:______________________________________________

______________________________________________

Dates:______________________________________________

**Immunization History**

Are all immunizations up-to-date? ☐ Yes ☐ No DTP or DT (Tetanus) Date: _______

If immunizations are not current, including the DTP, please submit a state certificate from physician or parent stating medical or religious reason.

**Medication Information**

Any prescribed medication being taken? ☐ Yes ☐ *Inhaler* ☐ *Epipen* ☐ No

If yes, please list medication and dosage: ______________________________

______________________________________________

**General Information – Please fill out all information**

Family Physician: ______________________________ Phone: ____________________

Health Insurance Company: ____________________ Policy #: ____________________

Insurance Company Address: ______________________________ City: ______

______________________________ State: __________ Zip: __________

*Please fill out the reverse side*