



Girl Scouts.
FAIRPORT GIRL SCOUT CAMPOREE 2010

MAY 14-16, 2010

PARENT/GUARDIAN PERMISSION FORM

BSA Camp Cutler, 7131 Gulick Rd., Naples, NY

TROOP# _____

PATROL# _____

Parents , please complete and sign front and back of form and return to your troop leader ASAP.

My daughter, _____

has permission to participate in Fairport Girl Scout Camporee 2010

My daughter may be photographed: YES or NO

She can participate with reasonable accommodations.

Yes No

Please describe: _____

During the activity, I (we) can be reached at:

Address: _____ Telephone number: _____

Cell number: _____

If I (we) cannot be reached in the event of an emergency, the following person is authorized to act in my (our) behalf:

Name: _____

Address: _____ Telephone number: _____

Relationship to participant: _____

Physician's name: _____ Telephone number: _____

Additional remarks: _____

Parent or guardian's signature _____ Date: _____

(must be signed)

PLEASE COMPLETE THE REVERSE SIDE *****

Troop# _____

Patrol# _____

PERTINENT MEDICAL INFORMATION

GIRL SCOUTS' NAME _____

LEADERS' NAME _____

PHYSICIANS NAME AND NUMBER: _____

INSURANCE CARRIER AND NUMBER: _____

DATE OF LAST PHYSICAL: _____

ARE ALL IMMUNIZATIONS UP TO DATE? (CIRCLE ONE) YES or NO

DATE OF LAST TETNUS: _____

FOOD ALLERGIES: _____

OTHER KNOWN ALLERGIES: _____

DOES YOUR CHILD USE AN INHALER? (CIRCLE ONE) YES or NO
IF YES, DOES YOUR CHILD HAVE YOUR PERMISSION TO CARRY THEIR INHALER?
(CIRCLE ONE) YES or NO

DOES YOUR CHILD NEED TO CARRY AN EPI-PEN? (CIRCLE ONE) YES or NO
IF YES DOES YOUR CHILD HAVE PERMISSION TO CARRY THEIR EPI-PEN ?
(CIRCLE ONE) YES or NO

PLEASE LIST ANY MEDICATIONS YOUR CHILD TAKE AS NEEDED OR ON A REGULAR BASIS
(Please include Motrin, Tylenol as needed for pain, headaches, fever, Aleve, aspirin, Midol, Sudafed,
Epi-pen, inhaler, specify medication name, cough syrups, Benadryl etc.)

As needed or daily	Name of medication	Shot, by mouth, topical etc	Dose of medication	Times to be given

PLEASE LIST ANY OTHER MEDICAL CONDITIONS THAT YOUR CHILD HAS: _____

BY SIGNING THIS FORM, YOU AUTHORIZE MEDICAL PERSONNEL AT THE CAMPOREE TO GIVE YOUR CHILD THEIR PRESCRIBED MEDICATIONS AS YOU HAVE INDICATED ABOVE.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____