

# 2017 GSLPG Summer Camp Adult Volunteer Registration Form

Your Name \_\_\_\_\_ Camper's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

E-mail \_\_\_\_\_ Name and date of camp \_\_\_\_\_

I can work at camp (check all that apply)  Mon  Tue  Wed  Thurs  Fri  Sat  Sun

Are you currently a registered Girl Scout?  Yes  no If yes, in what position? \_\_\_\_\_

I am a nurse  I am a lifeguard  I am able to be a unit leader  I am canoe trained  I have no preference

Girl Scout Experience \_\_\_\_\_

Other experience with children \_\_\_\_\_

Have you ever been convicted of a crime (other than a traffic violation)?  yes  no

If yes, please state the offense, date, and location (a conviction record will not necessarily be cause for disqualification) \_\_\_\_\_

T-shirt size (Optional): Adult    S    M    L    XL    2XL    3XL    4XL  
(Circle one)                    \$10   \$10   \$10   \$11     \$12   \$13     \$14

Person to notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Date of last health exam \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies \_\_\_\_\_

Major illnesses in the last 2 years \_\_\_\_\_

Prescription medicine you are on or have been on during the last (3) months  
\_\_\_\_\_

Please list any health conditions requiring medication, treatment, special restrictions or considerations while at camp.  
\_\_\_\_\_

I understand that in applying for this position, I am expressing my interest and belief in the principles expressed in the Girl Scout movement. I am willing to take training necessary for the job to which I am appointed. I certify that all information provided on this application is true and complete. I understand that falsification or significant omission of any information may be considered justification for dismissal if discovered at a later date. I give permission for the adult in charge to take me to or have me transported to a medical facility, if necessary. In case of emergency, if the above contact can not be reached, I agree to treatment for myself under the supervision of and deemed advisable by a licensed physician. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I agree to be financially responsible for all expenses associated with providing medical care for myself.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<b>OPTIONAL FEES:</b>	
Adult T-shirt(s).....	\$ _____
Patch (\$1.25 ea).....	\$ _____
Bus (\$15).....	\$ _____
Donation to help girls go to camp .....	\$ _____
Total enclosed .....	\$ _____