Service Unit #:
408

Adult Volunteer Registration Form
Camp Name and Fernald Preserve
6-3-25 to 6-6-25

Volunteer's Name: _____ Phone: _____

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

Email: _____ Cell Phone: _____

Volunteer is a: Currently registered Girl Scout Re-registering Girl Scout New Girl Scout

(If adult is not a currently registered Girl Scout member, you must register at https://www.gswo.org/join for $25)

Are you a leader/assistant leader? Yes No

Troop #: _____ Troop Grade Level in Fall: _____ Service Unit Name/#: _____

Do you have any daycamp experience? Yes No

I would like to be a unit leader and work with:

Girl Scout Daisies/Brownies Girl Scout Juniors My girl's unit

There is an adult at camp that I would like to work with (name) _____

T-Shirts (circle one):

Sizes: **Adult:** Small Medium Large X-Large XX-Large XXX-Large

Registrations will be accepted postmarked from _____ to _____

TOTAL FEES (payable to GSWO)	
Adult fees (if not volunteering all week)	$12.50
TOTAL	**$**

Mail completed Adult Registration Form to:
Nancy Benight
7251 Brooks Road
Harrison, OH 45030

***Additional steps will need to be taken to secure your Girl Scout volunteer role.** All adult volunteers are **required** to have a current Girl Scout membership and updated background check. Register and pay for your Girl Scout membership at **gswo.org/join** or contact Customer Care at 888.350.5090. Membership with a volunteer role will trigger an emailed criminal background check which needs to be completed once every 3 years.

Adults who do not have a current background check and or have not completed youth protection training will not be permitted to volunteer.

Signature: _____ ***Date:*** _____

Adult Medical and Release Form

girl scouts of western ohio

Name: _____ Phone: _____

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

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Insurance Company: _____ Member ID #: _____

Group ID #: _____ Insured Name: _____

Emergency Contacts

Name: _____ Relationship to Participant: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship to Participant: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list any conditions that a first-aid or health provider would need to know such as?

Allergies: _____

_____

_____

Medications: _____

_____

_____

Chronic Illnesses, injuries or limitations: _____

_____

_____

My immunizations are up to date: ☐ Yes ☐ No

	Year Primary Series completed	**Date of Last Booster**
Diphtheria/Whooping Cough/Tetanus		
(D.T. P.) Tetanus (TD)		
Measles/Mumps/Rubella (MMR)		
Oral Polio		
Tuberculin Test (Most recent)		

In the event that reasonable attempts to contact my designated person in an emergency have not been successful, I hereby give my consent for the administration of any treatment deemed necessary by medical personnel. This health history is complete and accurate.

_____ _____

Signature of Participant Date