French Park
Day Camp 4B

Camp H2O

Participate in a variety of outdoor activities and Girl Scout traditions.

Camper Costs:
Program Aides: $15

Registration Deadline:
May 15, 2023

Mon.-Fri., July 17-21, 2023
9:00 a.m.-2:30 p.m.
French Park
3012 Section Rd.
Cincinnati OH, 45237

Questions?
Contact: frenchparkdaycamp@gmail.com

girl scouts of western ohio

888.350.5090 | gswo.org
customercare@gswo.org

In Partnership With: United Way

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PA Camper Registration Form 2023

Camp H2O - Camp 4B

Camper's Name: _____ Phone: _____

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

School: _____ County: _____

DOB: _____ Age: _____ Grade in Fall: _____

Caregiver's Name: _____ Phone: _____

Caregiver's Email: _____

Custodial Care: ☐ Mother only ☐ Father only ☐ Both ☐ Other _____

Troop Leader's Name or Troop #: _____ Service Unit Name or #: _____

Camper is a: ☐ Girl Scout Member ☐ Re-registering Girl Scout ☐ New Girl Scout

Who will bring your PA to camp?

Driver's name: _____

T-shirts (included in fee): T-shirts cannot be returned or exchanged. If in doubt, order the next larger size.

T-Shirt Sizes: ☐ YS ☐ YM ☐ YL ☐ AS ☐ AM
☐ AL ☐ AXL ☐ A2X ☐ A3X

Camp Registration	
Day Camp Fee $15	$
Digital Dough	-$
Financial Assistance Amount Requested	- $
TOTAL Due	= $

Membership Fee: All campers must be registered Girl Scouts. To join Girl Scouts, the fee is an additional $25 for membership through September 30, 2023. (Please register and submit your $25 registration fee to be a Girl Scout by calling Customer Care at 888.350.5090, if renewing, please do the same.)

Financial Assistance: Register and pay for camp now for the amount that you can pay. A minimum of 50% of camp fee must be paid by camper. The Camp Director will contact you with the amount of financial aid that you received and if there is a balance owed.

Financial Assistance (if needed): Please complete the section below. To be answered by a caregiver: How would this girl benefit from day camp?

I give full permission for my child to attend day camp and participate in all activities. I agree to cooperate with the camp guidelines. I understand that my camper must have written permission to leave camp early or with someone other than a caregiver. If I cannot be reached in an emergency, I give permission to give emergency treatment to my child.

I acknowledge that COVID-19 is an extremely contagious virus that spreads easily in the community. I agree to adhere to Girl Scouts of Western Ohio and State and local guidelines/mandates. I will take all reasonable precautions to limit potential exposure for girls, volunteers, and families, based on Girl Scouts of Western Ohio and state guidelines. I will hold Girl Scouts of Western Ohio harmless and waive all rights to legal action, if my daughter contracts COVID through exposure at a Girl Scout event.

Caregiver Signature: _____ Date: _____

Mail completed Registration Form and Additional Information Heath Form to: **Tricia Klco** **6441 Ridge Ave.** **Cincinnati, OH 45213**	Girls will be accepted on a first come, first served basis based on the number of volunteers available and according to postmark. Priority will be given to girls with caregivers who are volunteering.

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Program Aide Information Form
Day Camp 4B–Camp H2O

Program aides will be assisting girls and adults with outdoor program activities during day camp. Program aides must be entering grades 8–12 in the fall of 2023. In addition, program aides must have completed their Leader in Action Award, Program Aide Leadership/Core Training and Day Camp Training before camp begins. Girls who have previously served as PAs are not required to complete the LiA or repeat the PA Leadership/Core Training.

Camper Name: _____

PA Training completion date: _____

PA Camp Name (i.e. Capt'n Crunch): _____

Level I would like to work with:

☐Daisy ☐Brownie ☐Junior ☐Pixies/Boys ☐Tie-Dye/Little House Aid ☐Cadette/Orange Unit

I will be attending the PA overnight on July 15 **Yes** ☐ No ☐

I have a tent that I will bring to the overnight. Yes ☐ **No** ☐

Number of people my tent can sleep_____

Caregiver's Name (please print): _____

Caregiver's Signature: _____ Date: _____

Phone number(s) where you can be reached during this activity: _____

HEALTH INFORMATION AND RELEASE FORM

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Health Information and Release Form

To be completed and reviewed annually by parent/caregiver or adult. This form should be kept with the troop/group records and accompany the troop/group leader on all troop/group activities. It is designed to provide the troop/group leader with the information needed to access medical care for your daughter. It should be reviewed and updated (as needed) when information changes.

Name: _____ Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____ Troop/Group #: _____

PART I: PARENT INFORMATION AND RELEASE

She is under the custodial care of:

Both Parents ☐ Mother/Caregiver only ☐ Father/Caregiver only ☐ Other (specify) _____

Mother/Caregiver Name _____

Address (if different than girl): _____

Employer: _____ Occupation: _____

Phone (day): _____ Phone (evening): _____ Cell Phone: _____

E-mail: _____

Father/Caregiver Name _____

Address (if different than girl): _____

Employer: _____ Occupation: _____

Phone (day): _____ Phone (evening): _____ Cell Phone: _____

E-mail: _____

PART II: EMERGENCY CONTACT AND RELEASE INFORMATION

In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

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: _____

ADDITIONAL RELEASE INFORMATION:

In addition to the above parent(s)/caregiver(s) and emergency contacts, this participant may also be released to the following persons:

Name: _____ Relationship to Participant: _____

Name: _____ Relationship to Participant: _____

PART III: HEALTH CARE INFORMATION:

Physician's Name: _____ Phone: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Dentist's Name: _____ Phone: _____

Dentist's Address: _____ City: _____ State: _____ Zip: _____

PART IV: ALLERGIES *(Check those that apply and specify nature of allergic reaction.)*

☐ Animals ☐ Hay Fever ☐ Pollen ☐ Food ☐ Insect Stings ☐ Plants ☐ Penicillin

☐ Other Medicines/Drugs: _____ ☐ Other (specify): _____

Girl Scout Leaders do not administer over-the-counter medications for complaints such as headaches, fever, stomachaches, sunburn, etc. If those medications are needed, parents must supply them with written instructions.

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted:

PART V: OTHER HEALTH CONDITIONS *(Check those that apply.)*

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted:

☐ Asthma	☐ Bed Wetting	☐ Bleeding/Clotting Disorders	☐ Constipation
☐ Convulsions/Seizures	☐ Diabetes	☐ Emotional/Behavior Disturbances	☐ Ear Infections
☐ Fainting	☐ Hearing Impairment	☐ Heart Defect/Disease	☐ High Blood Pressure
☐ Hypertension	☐ Menstrual Cramps	☐ Musculoskeletal Disorders	☐ Motion Sickness
☐ Sickle Cell Trait or Disease	☐ Nosebleeds	☐ Special Dietary Regimen	☐ Rheumatic Fever
☐ Sleep Disturbances	☐ Urinary Infections	☐ Wears Glasses or Contact Lenses	☐ Visual Impairment:

☐ Other (specify): Please explain any items that are checked. Indicate any information that would be useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

_____

_____

_____

PART VI: IMMUNIZATION HISTORY

Immunization	Year Primary Series Completed	Year of Last Booster
DTP (Diphtheria; Tetanus; Whooping Cough)		
Hepatitis B		
MMR (Measles/Mumps/Rubella)		
Oral Polio		
TD (Tetanus/Diphtheria)		
Tuberculin Test (most recent) Result		
Others:		

Which of the following has the participant had?
☐ Chicken Pox
☐ German Measles
☐ Hepatitis
☐ Measles
☐ Mumps

PART VII: MEDICATION *(For day outings or overnights only.)*

Current Medication(s): _____

Being Taken For: (condition) _____

Dosage and Frequency: _____

EMERGENCY MEDICAL AUTHORIZATION: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed troop/group activities except as specifically noted.

AUTHORIZATION FOR TREATMENT: In the event reasonable attempts to contact me at the above listed phone numbers have been unsuccessful, I hereby give my consent to the administration of emergency medical treatment by any licensed physician or dentist and to transfer the child to any reasonably accessible hospital facility. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Caregiver: _____ Date: _____

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name: _____ Policy or Group #: _____

Name of insured: _____ Relationship to participant: _____

Insurance ID number: _____