

Girls Only!

Robotics Camp

Are you a girl interested in technology?
Robotics? Then join us for a robotics camp
you won't want to miss!

Who: Girls interested in robotics and
technology in grades 4 and 5
**Registered Girl Scouts are suggested to
bring a non- Girl Scout friend!**

What: Robotics camp with activities designed
to get girls interested and involved with
robotics. Activities will include building,
programming and teamwork building
exercises using LEGO NXT Robots.

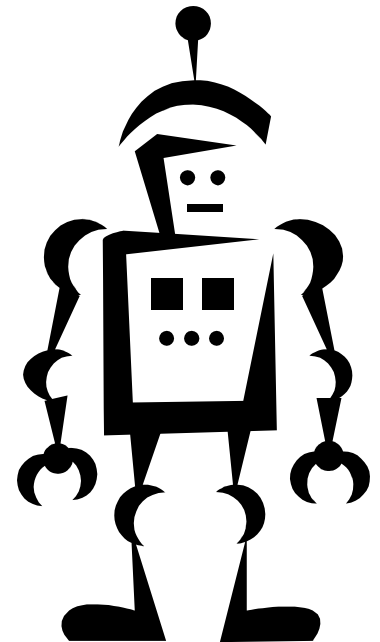
When: June 14- 15
1:00 PM- 5:00 PM

Where: Klein United Methodist Church
Wesley Hall
Parking lot in the back of church

Cost: **FREE**

Mail your registration forms to:

Christie Etter
8027 Twin Oaks Dr.
Spring, TX 77389





Girl's Name _____ Troop/Group # _____ Phone () _____
Home Address _____ City _____ State _____ Zip _____
Date of Birth _____ Date of last Health Exam _____
Girl's Physician/Clinic _____ Phone () _____
Parent/Legal Guardian _____ Phone () _____ Cell Phone () _____

HOSPITAL INSURANCE INFORMATION Attach photocopy of insurance card.

Name of Carrier _____ Policy # _____
Insured's name _____ Member ID# _____
Company name if insured through employer _____ Phone: () _____

Others who could be contacted to authorize treatments:

Name _____ Day() _____ Evn() _____ Relationship _____
Name _____ Day() _____ Evn() _____ Relationship _____

PART I

Allergies (Check those that apply. Specify cause and nature of reactions - e.g. penicillin causes hives.)

Animals Plants Food Medicine/Drugs _____
 Hayfever Pollen Insect Sting _____
Other: _____
In case of an allergic reaction, respond by _____

PART II

Health Conditions (Check those that apply.)

Chronic or reoccurring illness: _____
 Asthma Musculoskeletal Disorders Kidney Disease
 Diabetes Heart Disease/Defects Hypertension
 Seizures Bleeding/Clotting Disorder Ear Infection
Other: _____

IN THE LAST YEAR: (ANSWER YES OR NO)

Complicating medical problems/operations? _____ Serious injury/illness requiring medical care? _____

Explain: _____

SPECIFIC INSTRUCTIONS / ONGOING TREATMENTS: _____

PART III

Other Health Conditions (Check those that apply.)

Sleep disturbances Motion sickness Constipation/diarrhea Bedwetting
 Hepatitis A / B / C (circle one) Menstrual complications Sickle cell trait or disease ADHD / ADD
 Emotional disturbances Hearing impairment Special dietary regiment Fainting
 Physical disabilities Frequent headaches Wears contact lenses/glasses Nosebleeds
 Orthodontic appliances Eating disorders
Other (specify) _____

Please explain. Indicate any information useful to the adult in charge in relation to any of the above health conditions.
Indicate any activity to be encouraged or restricted _____

Dietary Needs / Restrictions: _____

| Immunization/Disease History (Please complete) | | | |
|---|-------------------------------|----------------------|-----------------|
| Immunization | Year Primary Series Completed | Year of Last Booster | Has had Disease |
| D.T.P. | | | |
| Diphtheria | | | |
| Pertussis (whooping cough) | | | |
| Tetanus | | | |
| Td (tetanus/diphtheria) | | | |
| Measles | | | |
| Mumps | | | |
| Rubella (German Measles) | | | |
| Chicken Pox | | | |
| Oral Polio | | | |
| Hib | | | |
| Hepatitis B | | | |
| Tuberculin Test Result (most recent) | | | |
| Other | | | |

| | | |
|---|---------|------------|
| Listed are medication(s) my child will routinely take with the supervision of the Leader/First Aider. (Attach a list if necessary.) | | |
| Medication: | Dosage: | How Often: |
| | | |

Over the Counter Medication(s):

She can have: _____

She **cannot** have: _____

Parent's/Legal Guardian's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all planned trip activities except as noted by the examining physician or me.

TRANSPORTATION RELEASE: I authorize transportation for my child by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of my child. It is my expressed intention to hold Girl Scouts of San Jacinto Council harmless for any and all injuries, death or damages arising from or in any way related to any such transportation.

CONSENT TO TREAT: I hereby give permission to the physician selected [by the trip coordinator] to order X-rays, routine tests and treatment for the health of my child, in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the first aider/trip coordinator to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to troop/group leaders, drivers, medical personnel, etc.

| | | | |
|---|--------------------|-----------------------|----------------|
| My signature confirms that the above information is correct to the best of my knowledge and that I am authorized to execute the information form and release. | | | |
| Signature of Parent/Legal Guardian | Full Name of Child | Relationship to Child | Date |
| _____ | _____ | _____ | _____ |
| Print Name of Parent/Legal Guardian | Day () _____ | Evn () _____ | Cell () _____ |
| _____ | _____ | _____ | _____ |
| Address | City | State | Zip |
| _____ | _____ | _____ | _____ |



GIRL SCOUT
Girl Scouts of San Jacinto Council

(THIS FORM MAY BE PHOTOCOPIED WHEN COMPLETED. PRINT CLEARLY, USE BLACK INK.)

GIRL'S NAME _____

TROOP/GROUP # _____

Parent/Legal Guardian to keep this portion

Activity/Place: _____ Date(s): _____

Leaving from: _____ Time of departure: _____

Returning to: _____ Time of return: _____

Bring: _____ Fee: _____

Dress: _____

Adult in charge: _____ Phone: (____) _____

Contact adult: _____ Phone: (____) _____

Cut above and return this portion to leader/adult in charge by: _____ (Date)

Girl's Name: _____ Troop/Group # _____ Age: _____

Activity: _____ Date: _____

My daughter has my permission to attend the activity listed above. She will not attend if she is not feeling well. I give my permission to have her treated by a licensed physician if necessary. I also agree to be financially responsible for all expenses associated with providing medical care for my child. My signature on this document also allows Girl Scouts to use photographs, voice, and/or video of my child for Public Relations purposes. My daughter may have opportunities in the future to attend activities other than the ones listed on this form. I acknowledge that if I give permission for her to participate in such activities in the future, it is under the same conditions that are set out in this form, including with respect to transportation. (Leader: Attach future parent permissions to this form.)

TRANSPORTATION RELEASE: I understand that troop/group leaders must obtain the written consent of parent/guardian for every girl wishing to participate in an activity or outing that is held at a different place and time from the regularly scheduled troop/group meeting. I accept responsibility for the transportation of my child to and from any Girl Scout activity and recognize that transportation to and from Girl Scout events is not the responsibility of Girl Scouts of San Jacinto Council. I recognize that the driver of any such carpool or bus service that I arrange is not acting as an agent of Girl Scouts of San Jacinto Council. It is my expressed intention to hold Girl Scouts of San Jacinto Council harmless for any and all injuries, death or damages arising from or in any way related to any such transportation.

I give my permission for my daughter to participate in Boating, Swimming, Horseback Riding, or other strenuous activities. If no exceptions, she may participate in all activities at this outing. **EXCEPTIONS:** _____

My daughter **may not** be released to: _____

If unable to reach me in case of an emergency or change in plans, please contact one of the following. I will make arrangements with these people prior to the event.

Name: _____ Day:(____) _____ Evn:(____) _____ Relationship: _____

Name: _____ Day:(____) _____ Evn:(____) _____ Relationship: _____

| | | |
|--|---------|------------|
| I have provided medication(s) for my child to take with the supervision of the Leader/First Aider. Yes: ____ No: ____ (attach a list if necessary) | | |
| Medication: | Dosage: | How Often: |
| | | |

Medication(s) she can have: _____

Medication(s) she **cannot** have: _____

Disease exposed to in last 30-days: _____

Signature of Parent/Legal Guardian _____ Phone # _____ Pager or Cell Phone _____ Date _____

Print Name of Parent/Legal Guardian _____