girl scouts
arizona cactus-pine

ADULT INFORMATION

O Mrs. O Ms. O Miss O Mr. O Dr. O Other_____

First Name_____ Last Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Email_____ Employer_____

As a volunteer, I would like to participate in the following role(s):

O 01 Advisor or Leader for a Group/Troop #_____ #_____ #_____

O 02 Assistant Advisor or Leader for a Group/Troop #_____ #_____ #_____

O 03 Support Volunteer for a Group/Troop #_____ #_____ #_____

O Other (specify)_____

I accept & abide by the Girl Scout Law.

_____
Signature Date

Girl Scouts respects and welcomes people from all backgrounds and abilities. By completing the following information (as defined by the US Cenus), you ensure support and funding for girls in your community. Hispanic/Latina is defined as an ethnicity, not a race, therefore reported separately. This information is used for statistical purposes only.

I am (check all that apply)

O American Indian or Alaskan Native O Asian O Black or African American
O Hawaiian or Pacific Islander O White O Other_____
O I choose to not share at this time.

I am Hispanic or Latina O Yes O No O I choose to not share at this time.

Gender O Female O Male

When participating in Girl scout activities I may be photographed for print, videotaped, or electronically imaged. Images may be used in promotional materials, news releases, and other published formats for either the local Girl Scout Councils or Girl Scouts of the USA. The images will be the sole property of either the local Girl Scout Council or Girl Scouts of the USA. O I wish to opt out at this time.

COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact. As with any social activity, participation in Girl Scouts could present the risk of contracting COVID-19. While GSACPC attempts to take every safety and preventative precaution, GSACPC can in no way warrant that COVID-19 infection will not occur through participation in GSACPC programs.

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ADULT HEALTH HISTORY

Council Emergency Phone: 602.531.5935

Emergency Contact

Name_____

Address_____

City_____ State_____ Zip_____

Phone_____ Cell Phone_____

The following information is commonly requested by the emergency treatment facility:

Date of Birth (mm/dd/yyyy)_____

Last Tetanus (approx date)_____

_____ _____
Name of Doctor/Healthcare Provider Phone

_____ _____
Name of Insurance Provider (if any) Policy/Group #

Please note any health condition or concern that should be considered during activities.

O Asthma
O Diabetes
O Convulsions
O Heart Disease
O Glasses/Contact Lenses
O Kidney/Bladder Problems

Other_____

Other_____

Allergies – please specify

O Asthma_____
O Medicine/Drugs_____
O Foods_____
O Hay Fever_____
O Insect Stings_____
O Other_____

I do hereby authorize medical attention from a qualified and licensed medical doctor/healthcare provider in the event of a medical emergency, and the transportation to a medical facility if required.

_____ _____
Signature Date