



**BOSTON** 95 Berkeley St, 02116, 617.482.1078 • **LOWELL** 16 Stedman St, 01851, 978.970.0644 • **LYNN** 583 Chestnut St, 01904, 781.592.5182 • **MIDDLEBORO** 111 East Grove St, 02346, 508.923.0800 • **NORTH ANDOVER** 1740 Turnpike St, 01845, 978.689.8015 • **WALTHAM** 265 Beaver St, 02452, 781.893.6113

Program Aides are needed to assist at various Day Camps throughout the council. To qualify you must be a registered Girl Scout entering grades 8 - 12. Program Aide Core Training and Program Aide Camp Skills Training are a must. Experience is helpful. Sense of humor and ability to work with other Girl Scouts is crucial. If interested, complete the application below and include a medical immunization record form (NOTE: Day Campers only need to provide a current immunization medical record form, they do not need to get a current physical) and send it to the Girl Scout Council of Southeastern Massachusetts, 111 East Grove Street, Middleboro, MA 02346, Attention: Jamielee Croteau, Day Camp Director, Camp Greenbrier & Camp Greenough. **No application will be accepted without a immunization record.**

**DAY CAMP PROGRAM AIDE APPLICATION**

Name \_\_\_\_\_ Camp Nickname \_\_\_\_\_ Telephone \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
(#/Street/PO Box) (City/Town) (State) (Zip Code)

Date of Birth \_\_\_\_\_ Grade Fall of 2008 \_\_\_\_ Current Troop Number \_\_\_\_ Email \_\_\_\_\_  
(Month/Day/Year)

Check which of the following applies to you and then give us details below:

I am a Trained Program Aide and I have Camp Experience  I am a Trained Program Aide, without Camp Experience  
 Program Aide Training Dates \_\_\_\_\_ Trainer's Name \_\_\_\_\_  
 Camp Experience \_\_\_\_\_

Please list any certificates (lifesaving, first aid, CPR, etc.) leadership positions or service training bars you hold. \_\_\_\_\_

**Girl Scout Leadership Reference.** Please supply the name of your current Girl Scout leader or someone who knows your leadership skills. This person may be asked to supply a reference for you as a Program Aide.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Summer Programs:** Please indicate the dates on the line(s) below. See camp book or [www.gscsm.org/camp](http://www.gscsm.org/camp) for specific dates

Camp \_\_\_\_\_ Dates \_\_\_\_\_  
 Camp \_\_\_\_\_ Dates \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Applicant

**Parental Permission:**

I hereby give my child, \_\_\_\_\_, if accepted, permission to be a Program Aide at \_\_\_\_\_ Day Camp from \_\_\_\_\_ until \_\_\_\_\_  
(Date) (Date)

\_\_\_\_\_ Date Signature of parent/legal guardian

**Consent for Medical and Emergency Treatment:**

I understand in the case of emergency, every effort will be made to contact a parent/guardian prior to treatment. If the parent/guardian cannot be reached, and the situation requires immediate emergency attention as determined by camp staff, I hereby authorize representatives of Girl Scout Council of Southeastern Massachusetts to obtain emergency treatment for this child.

\_\_\_\_\_ Date Signature of parent/legal guardian

**Program Aide Skills**

As a Program Aide you will be expected to help adults lead younger girls.

Please list any skills that you have acquired through PA Training and/or Camp experience that you feel will be an asset to the adult Volunteers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any Program Aide experiences: (i.e., summer camp, Council events, helping with younger troops)

\_\_\_\_\_  
\_\_\_\_\_

What contribution do you feel you can make to the camp, campers and staff as a Program Aide?

\_\_\_\_\_  
\_\_\_\_\_

Please put a number 1 next to the activities you feel you could lead, a number 2 next to those which you believe you can assist.

- \_\_\_ Artistic Skills \_\_\_ Knowledge of Nature
- \_\_\_ Drama Skills \_\_\_ Cultural Knowledge
- \_\_\_ Song Teaching \_\_\_ Travel Experience
- \_\_\_ Dance Skills \_\_\_ Flag Ceremonies
- \_\_\_ Fire Building \_\_\_ Craft Experience
- \_\_\_ Orienteering \_\_\_ Leadership Skills

\_\_\_ Please List any other experiences that you feel would better enable you to be a Program Aid at Day camp:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Required Medical History and Consent for Treatment - All Camps

This form, completed, is a required part of every application and must be submitted as part of the application packet. Multiple copies for multiple programs for the same child, even at the same camp, are required. No space is held for incomplete applications.

Resident  Day  WIP  ERead  Gbrier  Cape  MV Program \_\_\_\_\_ Dates \_\_\_\_\_

Resident  Day  WIP  ERead  Gbrier  Cape  MV Program \_\_\_\_\_ Dates \_\_\_\_\_

Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street/Mailing Address \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Age \_\_\_\_\_

Parent/guardian \_\_\_\_\_ Day phone \_\_\_\_\_ Eve phone \_\_\_\_\_

Address \_\_\_\_\_

Parent/guardian \_\_\_\_\_ Day phone \_\_\_\_\_ Eve phone \_\_\_\_\_

Address \_\_\_\_\_

IN CASE OF EMERGENCY if parent/guardian cannot be reached, name of person to notify or to whom to release camper:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

If there are unusual issues related to the release of your child, please attach details with application.

### CHECK ALL CAMPER HAS OR HAS HAD

- Constipation
- Bed wetting
- Sleepwalking
- Motion sickness
- Nausea
- ADD/ADHD
- Freq sore throats
- Seizures
- Homesickness
- Asthma
- Diabetes
- Sinusitis
- Kidney trouble
- Eating disorder
- Tuberculosis
- Heart trouble
- Glasses, contacts
- Emotional issues
- Depression
- Bronchitis
- other, specify \_\_\_\_\_

Of above, these are current or recurring \_\_\_\_\_ Dietary Restrictions \_\_\_\_\_

ALLERGIES  Bee stings  Drugs: \_\_\_\_\_  Foods: \_\_\_\_\_  Other: \_\_\_\_\_

Recently exposed to contagious disease? Y N If yes, which? \_\_\_\_\_ When? \_\_\_\_\_

Menstruates? Y N Menstruation normal? Y N If no, explain \_\_\_\_\_ If doesn't menstruate, knows about it? Y N

If hospitalized within past 5 years, explain \_\_\_\_\_

Describe health conditions requiring restrictions on participation in camp programs \_\_\_\_\_

Describe current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at camp: \_\_\_\_\_

Name of camper's physician or health care provider \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Insurance company \_\_\_\_\_ Member number \_\_\_\_\_

Insurance company address \_\_\_\_\_

**REQUIRED PARENT/GUARDIAN CONSENT** This medical history is correct as far as I know. I understand that in the case of an emergency, every effort will be made to contact a parent or guardian prior to treatment. If a parent or guardian cannot be reached, however, and the situation requires immediate emergency attention as determined by camp staff, I hereby authorize representatives of Girl Scout Council of Southeastern Massachusetts to obtain emergency treatment for my child as deemed necessary by Girl Scout representatives. I give permission for any or all medical and other information to be given to others if deemed by the camp's health care supervisor to be necessary for the health and well-being of my child. Girl Scout Council of Southeastern Massachusetts, its officers, board members, leaders, employees and agents will not be held liable for procedures performed pursuant to this consent. Photocopies of this form may serve the purpose of the original for trips away from camp.

**MEDICATIONS, PRESCRIPTION:** State law requires parental authorization to administer prescription medications. Prescribed medication **MUST** be in its original container with pharmacy label showing number, patient name, date filled, physician name, name of medication and directions for use. I authorize the camp health care supervisor or designated First Aider to administer to my child any prescribed medications she brings.

**NON-PRESCRIPTION:** I authorize the health care supervisor or designated First Aider to administer these non-prescription medications in brand or generic form if necessary for camper's comfort:  Advil  Tylenol  Antacid  Antihistimine  Sunscreen  Throat lozenge  Insect repellent ( with DEET)  Motion sickness suppressant  Menstrual relief  KI pills, in event of declared nuclear emergency  
Other: \_\_\_\_\_

SEE REVERSE TO LIST ALL MEDICATIONS THIS CHILD IS BRINGING WITH HER TO CAMP.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_

**DAY AND RESIDENT CAMPERS PERMISSION TO CARRY EPI-PENS AND INHALERS**

Camper's Name: \_\_\_\_\_ Camp session: \_\_\_\_\_

Camper does **not** use epi-pen or inhaler. Camper uses  epi-pen  inhaler, **to be kept in Camp Healthcare Office.**

**For Campers who need to carry and self administer epi-pens and inhalers:**

The Massachusetts Department of Public Health has issued a special directive to summer camps regarding children who carry their own Epi-pens and inhalers: *If a camper comes to camp with a prescription Epi-pen or inhaler and the child is capable of self-medicating and the parent and the camp health care consultant give written approval, the camper may be allowed to carry these devices with her/him at all times and to use them if so required.*

This directive was issued because all other medications must be held and administered by the camp health care supervisor, not by the camper. If your child uses either of these devices and you believe she is capable of carrying and administering the device herself, sign the authorization below, and we will submit it to the camp's Health Care Consultant for approval.

PLEASE PRINT: I, \_\_\_\_\_, parent/guardian of the above Camper, hereby state that I wish this camper to be allowed to carry and self-administer her own prescribed (circle) EPI-PEN INHALER at camp.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**DAY AND RESIDENT CAMPERS IMMUNIZATION MONTH/YEAR WITH PHYSICIAN'S SIGNATURE IS REQUIRED BY THE DEPT OF PUBLIC HEALTH. IMMUNIZATIONS MUST BE CURRENT.**

Hepatitis B (3, DOB after 1/92) \_\_\_\_\_ Measles, mumps, rubella (2) \_\_\_\_\_  
Polio (3-4) \_\_\_\_\_ Tuberculin tests \_\_\_\_\_  
Diphtheria, tetanus, pertussis (4) \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date of signature \_\_\_\_\_

Printed name or stamp \_\_\_\_\_ Phone \_\_\_\_\_

***The Massachusetts Dept of Public Health requires that all resident campers have had a complete physical exam by a licensed physician within 24 months of entering camp.***

**RESIDENT CAMPERS REPORT OF LICENSED PHYSICIAN**

Patient's name \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Date of Exam \_\_\_\_\_

List conditions for which patient is currently under care PHYSICAL \_\_\_\_\_ PSYCHOLOGICAL \_\_\_\_\_

List serious accidents and injuries that have occurred during past 6 months \_\_\_\_\_

Describe physical conditions requiring restrictions on participation in camp programs \_\_\_\_\_

I hereby state, with noted exception, that this person is in apparent good health and is physically able to participate in strenuous activities like swimming, boating, hiking and other outdoor activities.

Physician's signature \_\_\_\_\_ Date of signature \_\_\_\_\_

Printed name or stamp \_\_\_\_\_ Phone \_\_\_\_\_

**LIST ALL MEDICATIONS AND VITAMINS, PRESCRIPTION AND OVER-THE-COUNTER, THAT YOUR CHILD IS BRINGING WITH HER TO CAMP, AND THEIR PURPOSE.**

\_\_\_\_\_  
\_\_\_\_\_