

## PARENT/GUARDIAN TRIP/EVENT PERMISSION FORM

### Part A – To be completed by Troop/Group Leader/Advisor and kept by parent/guardian

Troop/Group # \_\_\_\_\_ is planning a Trip/Event to \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
street City state zip

Type of Activity: \_\_\_\_\_

Arrangements for transportation: \_\_\_\_\_

Time and place of departure: \_\_\_\_\_

Time and place of return: \_\_\_\_\_

Name(s) of Troop/Group Leaders/Advisors accompanying girls: \_\_\_\_\_

Cost of trip/event for girl: \$ \_\_\_\_\_ Troop/Group \$ \_\_\_\_\_ = Total cost \$ \_\_\_\_\_ per person

Cost of trip/event for parent: \$ \_\_\_\_\_ Troop/Group \$ \_\_\_\_\_ = Total cost \$ \_\_\_\_\_ per person

Equipment and/or clothing each girl will need: \_\_\_\_\_

Equipment and/or clothing each adult will need: \_\_\_\_\_

Optional: \_\_\_\_\_

In case of an emergency, the Leader/Advisor will notify: Name \_\_\_\_\_ Phone \_\_\_\_\_  
who will immediately notify the parents/guardians.

Date form sent to parent/guardian: \_\_\_\_\_ Date signed form due back to Troop/Group Leader/Advisor: \_\_\_\_\_

Leader/Advisor Signature: \_\_\_\_\_

Additional Remarks: \_\_\_\_\_

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### Part B – To be completed by parent/guardian and returned to Troop/Group Leader/Advisor

My Girl Scout \_\_\_\_\_ has permission to participate in \_\_\_\_\_ on \_\_\_\_\_

She may receive treatment from certified First Aiders/CPR, if necessary, while on the trip/event.

**Sleeping Arrangements:** My Girl Scout may  may not  share a bed designed for more than one person with another girl. A girl will not share a bed with an unrelated adult.

During this activity, I may be reached at:

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

If I cannot be reached in the event of an emergency, the following person is authorized to act on my behalf:

\*Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

**\*If both are unavailable, the Leader/Advisor or First Aider/CPR is  is not  authorized to act on my behalf.**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Any over-the-counter or prescribed medications should be in the original container and administered by the girl in the prescribed dosage in the presence of the responsible adult as per the written instruction by custodial parent, guardian, or physician.

Medication being taken (specify): \_\_\_\_\_

(over-the-counter or prescribed)

Special needs/limitations/allergies: \_\_\_\_\_

Additional remarks: \_\_\_\_\_

**In addition to this form, a completed Girl Health Record signed by the parent/guardian within the current year is required.**

Parent/Guardian Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

**\* Original signature required**