girl scouts of southern arizona

# Adult Information

○ Mrs. ○ Ms. ○ Miss ○ Mr. ○ Dr. ○ Mx. 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):**

○ Leader for a Group/Troop #_____ #_____ #_____

○ Co-Leader for a Group/Troop #_____ #_____ #_____

○ Troop Support Volunteer for a Group/Troop #_____ #_____ #_____

○ 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 Census), 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)

○ American Indian or Alaskan Native ○ Asian ○ Black or African American

○ Hawaiian or Pacific Islander ○ White ○ Other ____________

○ I choose to not share at this time.

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

**Gender** ○ Female ○ 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.* I wish to opt out at this time.

December 2023

*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 GSSOAZ attempts to take every safety and preventative precaution, GSSOAZ can in no way warrant that COVID-19 infection will not occur through participation in GSSOAZ programs.*

# Adult Health History

## Council Emergency Phone: (520) 977-6623

**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 # ____________

**What illnesses, injuries, allergies or health conditions—if any—should we be aware of to best support you?**

**Please indicate any activities to be encouraged or restricted as pertaining to your health needs.**

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 ______

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