girl scouts of michigan shore to shore

Troop Trip Treatment Permission Form

This form allows for the Girl Scout First Aider to provide the listed medicines, treatments, food, or care without prior notification to a Girl Scout's parents/guardians.

Girl Scout's First Name: _____ Date of Trip/Activity: _____

Please provide your permission by initialing each treatment the Girl Scout First Aider may administer:

_____ Acetaminophen

_____ Ibuprofen

_____ Benadryl

_____ Band-Aid

_____ Calamine/Caladryl lotion

_____ Eye/ear irrigation solution

_____ Hydrocortisone lotion

_____ Ice/Warm packs

_____ Skin cleansing agent

_____ Topical (skin) antibiotic

_____ Application of insect repellent, only if provided by parent/guardian.

_____ Application of sunscreen, only if provided by parent/guardian.

_____ Administration of prescription medication, only if provided by parent/guardian in original container and with specific instructions for administration provided by parent/guardian.

My Girl Scout needs the following medications, treatments, food, or care. For medications include the name of the medication, the dosage, times and dates to be administered, and the reason for the medication. The medication must be in the original container and given to the Girl Scout First Aider.

Medication: _____

Treatment: _____

Food: _____

Care: _____

Turn over to sign and complete

All treatments must be documented on the Medication/Treatment Log. I give my permission for the above treatments as initialed/described above.

Parent/Guardian Printed Name	Parent/Guardian Printed Name
Parent/ Guardian Signature	Parent/ Guardian Signature
Date:	Date:

If only one parent/guardian signs, signer represents that the consent of any other parent/guardian has been obtained and/or is not needed.

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Medication/ Treatment Log

Girl Scout's Full Name: _____ Date of Trip/Activity: _____

The following medicines, treatments, food, or care were administered by the Girl Scout First Aider to the above named Girl Scout during the trip/activity with Troop _____ of Girl Scouts of Michigan Shore to Shore on_____(date).

Note: None if blank.

	Medicine/Treatment/Food/Care	**Signature of Person Providing Treatment**	**Date and Time**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____