

**ZWIĄZEK HARCERSTWA POLSKIEGO**  
**Polish Scouting Association in Canada**

**Permission Form / Pozwolenie**

**Samodzielny Szczep „Rysy” / Hufiec „Pomorze” – OBÓZ 2017**

Participant's Name: \_\_\_\_\_ Stopień: \_\_\_\_\_ Szczep \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Health Card Number \_\_\_\_\_

Participant's Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent(s)/Guardian Names: \_\_\_\_\_

Mother's Work/Mobile Phone: \_\_\_\_\_ Father's Work /Mobile Phone: \_\_\_\_\_

Contact E-mail address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_  
*(other than parent(s)/guardian listed above)*

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

**PERMISSION / POZWOLENIE**

I give permission for \_\_\_\_\_ to take part in the Summer Camp (Obóz Harcerski)  
(participant's Name & Surname)  
taking place at Ernest Poole Camp, Wabamun, Alberta from July 2<sup>nd</sup> to 12<sup>th</sup>, 2017.

The camp program includes the following activities: walking and hiking, swimming, canoeing, singing, crafts, outdoor sports and activities, and games.

Permission is given to take part in all activities, except for: \_\_\_\_\_

I release and agree to indemnify and hold harmless the Polish Scouting Association, its units, members and volunteers from any liability concerning my Participant child's involvement in approved scouting activities.

I understand that photographs may be taken during this scouting activity by the organizers, and the resulting images may be used in the Association's brochures and promotional materials including the Association's websites, without further notice to me, and I consent to such use of the photos.

I understand that, in the event my child is sent home due to a violation of the standards of conduct, I will bear all costs of the transport home and I acknowledge that I will receive no reimbursement of scouting or activity fees.

Parent's/Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's/Guardian's name (please print): \_\_\_\_\_

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By signing below, I agree to abide by all rules, regulations and procedures and standards of conduct as prescribed by the Polish Scouting Association and its units.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PARTICIPANT'S NAME:** \_\_\_\_\_

**EVENT & DATE:** *Obóz Harcerski, July 2-12, 2016*

**ALLERGIES / ASTHMA**

List any allergies such as food, insect stings, drugs, etc. Clearly explain allergy and/or asthma symptoms. If reaction is severe, please make certain that the severity of the reaction is clearly indicated and whether the participant carries an EpiPen. If more space is required to explain the medical concern, please attach the explanation on a separate piece of paper.

Allergy/Asthma	Rate Severity		Specific Type of Reaction	Usual Treatment
	mild	severe		
	1	2 3 4 5		
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DIETARY RESTRICTIONS**

List any foods the participant should not eat for medical reasons. If foods are life threatening, explain the symptoms and indicate if the participant carries an EpiPen for this purpose.

**MEDICAL CONDITIONS**

Please check off any life threatening conditions, physical limitations or any other concerns which might affect participation in the program.

Epilepsy	yes	no	Fainting Spells	yes	no
Diabetes	yes	no	Digestive Upsets	yes	no
Migraine Headaches	yes	no	Sleepwalking	yes	no
Bleeding Disorder	yes	no	Chronic Ear, Nose, Throat Infections	yes	no
Urinary Infections	yes	no	Nosebleeds	yes	no
Medic Alert Information	yes	no	Bed Wetting (if yes, please supply Depends)	yes	no
Medic Alert For:	_____	_____	Other	_____	_____

Details for usual treatment:

**MEDICATION** (information for day or overnight trips)

The medication being carried by the participant will be monitored by a counsellor or registered medical staff:

Name of Medication	Dosage	Method of Administration	Reason	Self* Medicating?

\* Self indicates the participant is in possession of the medication.

If necessary, may over the counter medications be administered in instances of fever, cold and/or minor discomfort (i.e Tylenol, Motrin, Benadryl, cold syrup, etc.)? YES NO

Has the participant received a Tetanus shot within the last 10 yrs? YES NO

\_\_\_\_\_ Date of last Tetanus shot

**CONSENT/POZWOLENIE REGARDING (PARTICIPANT'S NAME):** \_\_\_\_\_

In the event that medical care is required, I understand that every effort will be made to contact me. I acknowledge that in the case of an emergency, medical treatment may be sought by an Instructor and/or provided by health care practitioners without my consent. I hereby authorize the Scouting Instructors to secure such medical advice and services as may be required for the health and safety of myself or my child (or ward). I agree to accept financial responsibility in excess of the benefits allowed by my Provincial Health Plan and to reimburse registered camp staff for medical prescriptions purchased for my child.

*W wypadku potrzeby uzyskania opieki medycznej, rozumiem ze Instruktorzy/Druzynowi prowadzacy zajecia doloza wszelkich mozliwych staran by sie ze mna skontaktowac. Rozumiem ze w sytuacjach naglych interwencja medyczna moze nastapic bez mojego pozwolenia. Upowazniam osoby prowadzace harcerskie zajecia do zasiegniecia potrzebnej opieki medycznej dla zapewnienia zdrowia i bezpieczenstwa mojego lub mojego dziecka (czy mojego podopiecznego). Przyjmuje odpowiedzialnosc finansowa za koszty nie pokryte przez rzadowy plan zdrowia tacznie z lekami na receptę zakupionymi dla mojego dziecka.*

Signature of Parent/Guardian (or participant if over 18 years of age)

\_\_\_\_\_ Date

**Note:** The signature of a physician is only required for a participant with a life threatening medical condition.

Physician's Name: \_\_\_\_\_ Physician's Telephone Number: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_