ZWIAZEK HARCERSTWA POLSKIEGO
Polish Scouting Association in Canada
Permission Form / Pozwolenie

Event: _____ Date(s): _____
(i.e. Zimowisko harcerskie/zuchowe, biwak majowy, wycieczka)

Participant's Name: _____ Zuch: ____ H-ka/rz: ____ Wędro: ____

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: _____

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.

W wypadku potrzeby uzyskania opieki medycznej, rozumiem ze Instruktorzy/Drużynowi prowadzący zajęcia dołożą wszelkich możliwych starań by się ze mną skontaktować. Rozumiem ze w sytuacjach naglych interwencja medyczna może nastąpić bez mojego pozwolenia. Upoważniam osoby prowadzące harcerskie zajęcia do zasięgnięcia potrzebnej opieki medycznej dla zapewnienia zdrowia i bezpieczeństwa mojego lub mojego dziecka (czy mojego podopiecznego). Przyjmuje odpowiedzialnosc finansowa za koszty nie pokryte przez rzadowy plan zdrowia.

_____
Signature of Participant (or parent/guardian if participant is under 18 years of age)

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: _____