ZWIAZEK HARCERSTWA POLSKIEGO
Polish Scouting Association in Canada
Permission Form / Pozwolenie
2011-2012

Szczep Rzeka
(jednostka)

Participant's Name:_______________________________________Stopien_________________________

Date of Birth (M/D/Y):_________________________ Health Card Number ___________________________

Participant's Home Address:____

City:_______________ Province:________ Postal Code:____________ Home Phone:_______________________

Allergies: ____

Parent(s)/Guardian Names:____

Contact E-mail address: ____

Mother's Work/Mobile Phone #:____________________ Father's Work /Mobile Phone:____________________

Emergency Contact Name:________________________ Emergency Contact Number:______________________

PERMISSION / POZWOLENIE

I give permission for ____ to take part in the
(participant's Name & Surname)
POLISH SCOUTING PROGRAM IN TORONTO from **September, 2011** to **June, 2012, including** weekly **meetings (zbiorki) at Lambton Kingsway JMS, 525 Prince Edward Drive, Toronto, ON. on Fridays from 6:30-8:00 (9:00) , and additional activities at such other times and places as will be communicated from time to time.**

Activities involved in weekly meetings include games, singing, crafts, indoor and outdoor sports and training. 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): ____

____

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: ________________

POLISH SCOUTING ASSOCIATION IN CANADA (ONTARIO) INCORPORATED

HUFIEC "WATRA" - EMERGENCY/ PERSONAL HEALTH FORM

PERSONAL INFORMATION

Participant's Name: ____________________ Birth Date: ____________
Surname Given Name Year Month Day

Participant's Address: ____________________
No. Street Apt No. City Province Postal Code

Participant's Telephone: ____________________

Mother's or Guardian's Name: ____________________
Surname Given Name

Mother's or Guardian's Address: ____________________
(if different from Above) No. Street Apt No. City Province Postal Code

Father's or Guardian's Name: ____________________
Surname Given Name

Father's or Guardian's Address: ____________________
(if different from Above) No. Street Apt No. City Province Postal Code

EMERGENCY TELEPHONE NUMBERS

Parent's or Guardian's Name: ____________________ Home Telephone: ____________ Business Telephone: ____________
Surname Given Name

Parent's or Guardian's Name: ____________________ Home Telephone: ____________ Business Telephone: ____________
Surname Given Name

Family Doctor's Name: ____________________ Telephone: ____________

RELATIVE OR PERSON TO BE NOTIFIED IF PARENTS CANNOT BE REACHED

Name: ____________________ Home Telephone: ____________ Business Telephone: ____________
Surname Given Name

Relation to Participant: ____________________

HEALTH INSURANCE

Ontario Health Card Number: ____________ Name on Card: ____________
(as it appears)

OR

Other Hospital Insurance: ____________________
(name & numbers)

ALLERGIES / ASTHMA

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

Allergy/Asthma	Rate Severity (mild – severe)	Specific Type of Reaction	Usual Treatment
	1 2 3 4 5		
	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.

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MEDICAL CONDITIONS

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

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	yes	no

Medic Alert For: ____________________ Other ____________________

Details for usual treatment: ____________________

____

____

MEDICATION

The medication being carried by the Participant will be monitored by a Camp Leader:

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

* Self indicates the Participant is in possession of the medication.

If necessary, may Tylenol be administered to relieve minor discomfort ? ________ yes/no

Has the Participant received a Tetanus shot within the last 10 yrs? ________ yes/no ____________________ Date of last Tetanus shot

LIMITATIONS/PARTICIPATION

Please explain any limitations or other concerns which might affect participation in the program:

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CONSENT/POZWOLENIE

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 a Camp Leader and/or provided by health care practitioners without my consent. I hereby authorize the Camp Leaders 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 że organizatorzy/prowadzący Akcję Letnią dołoż wszelkich możliwych starań by się ze mną skontaktować. Rozumiem, że w sytuacjach nagłych interwencja medyczn może nastąpić bez mojego pozwolenia. Upoważniam osoby prowadzące harcerską Akcję Letnią do zasięgnięci potrzebnej opieki medycznej dla zapewnienia zdrowia i bezpieczeństwa mojego lub mojego dziecka (czy mojego/ podopiecznego/ej). Przyjmuje odpowiedzialność finansową za koszty niepokryte przez rządowy plan zdrowi

____________________ ____________________

Signature of Participant (or parent/guardian if applicant is under 18 years of age) Date

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

____________________ ____________________

Signature of Physician Physician's Telephone Number