Admin: Cash / Czek # Czeku: _____ Kwota: _____ Rachunek Potrzebny: _____

ZWIAZEK HARCERSTWA POLSKIEGO - Polish Scouting Association in Canada

Permission Form / Pozwolenie

Szczep Wodny Baltyk - *2018/2019*

Zuch ☐ Harcerz ☐

Participant's Name: _____ Stopień/Gwiazdki: _____ Numer Druzyny/Imie Gromady: _____

Date of Birth (D/M/Y): _____ Health Card Number (Req'd): _____

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: _____

Składki roczne do **Szczepu Bałtyk** wynoszą **$150 za jednego** uczestnika. Składki roczne wynoszą $250 za dwóch uczestników, $345 za trzech uczestników i $440 za czterech uczestników.
Po 31go października, każdy uczestnik płaci o $5 więcej: za jednego $155, za dwóch $260, za trzech $355, za czterech $5460.
Dodatkowe (Harcerze): Książka Harcerska Bałtyku (Stopnie, Wiedza, i Piosenki) $20; Śpiewnik Bałtyku $20.

Czeki proszę wystawiać na „PSA ZHP Baltyk".

Electronic Mail Transfer (E-Transfer): szczep.wodny.baltyk@gmail.com

Dla harcerzy: Książka Harcerska Bałtyku ☐ Śpiewnik Bałtyku ☐

PERMISSION / POZWOLENIE

I give permission for _____ to take part in the
(participant's Name & Surname)

POLISH SCOUTING PROGRAM IN **MISSISSAUGA** from September 11, 2018 to June 20, 2019, including weekly meetings (zbiorki)
For Zuchy: Willow Way Elementary/Public School (1715 Willow Way) on Tuesdays from 18:15 to 20:00; and
For Harcerze: Ray Underhill Public School (32 Suburban Dr.) on Tuesdays from 18:00 to 20:00; and additional activities at such other times and places as will be communicated from time to time. Both locations are 2km away from each other.

POLISH SCOUTING PROGRAM IN **ETOBICOKE** from September 13, 2018 to June 22, 2019, including weekly meetings (zbiórki)
For Zuchy: St. Leo Catholic School (165 Stanley Ave.) on Thursdays from 18:45 to 20:15; and
For Harcerze: St. Leo Catholic School (165 Stanley Ave.) on Thursdays from 18:30 to 20:30; 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.

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.
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.

Parent's/Guardian's signature: _____ Date: _____

Parent's/Guardian's name (please print): _____

PARTICIPANT'S NAME: _____ ***EVENT & DATE: 2018/2019 Scout Registration***

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 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 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 advicee 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/Drużynowi prowadzący zajęcia dołożą wszelkich możliwych starań by się ze mną skontaktować. Rozumiem ze w sytuacjach nagłych 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 odpowiedzialność finansowa za koszty niepokryte przez rządowy plan zdrowia łącznie z lekami na receptę zakupionych dla mojego dziecka.

_____ _____

Signature of Participant (or parent/guardian if participant 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.

Physician's Name: _____ Physician's Telephone Number: _____

Signature of Physician: _____ Date: _____