|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Insert Logo/ Wstaw Logo | | | | | **Związek Harcerstwa Polskiego Okręg w Wielkiej Brytanii**  **Polish Scouting Association UK Region** | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| ***Jednostka, Sztab, Organizacja Komenda akcji wypelnia*** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Event / Nazwa Akcji | | | Komenda Akcji wypełnia | | | | | | | | | | | | | | | | | Start date/ data rozpoczęcia: | | | | | | | dd | | | / | mm | | | | / | | yyyy | | |
| Komenda Akcji wypełnia | | | | | | | | | | | | | | | | |  | | |  |  | | | |  | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Adult Declaration and Medical Form for overnight scouting event**  **Deklaracja Osoby Dorosłej i Karta Zdrowia na harcerską akcję noclegową** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All personal information including sensitive personal information collected on this form will be processed in accordance with the PSA UK Region Privacy Notice which is available at <http://www.zhpwb.org.uk/okreg-wielko-brytyjski/dokumenty/> or from the unit leader | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surname/Nazwisko: | | | | | | |  | | | | | | | | | | | Given Name/Imię: | | | | | | | |  | | | | | | | | | | | | | |
| Home Address/ Adres zamieszkania: | | | | | | |  | | | | | | | | | | | | | | | | | | Tel. No. / Nr. Tel | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you entitled to free NHS medical treatment in the UK, by virtue of your UK Nationality, leave to remain in the UK, Settled status or, any other international agreements. / Czy posiadasz prawo do bezpłatnej opieki medycznej w ramach NHS w W.B., z tytułu obywatelstwa brytyjskiego, pozwolenia na stały pobyt w W. B., statusu osoby osiedlonej lub, innych uzgodnień międzynarodowych. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak  No/Nie | | | | | |
| If not, then you will need to arrange payment for any medical care you receive.  Jeśli nie, to będziesz musiał zorganizować opłatę za otrzymaną opiekę medyczną. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| NHS Number/Numer NHS: | | | | | | | |  | | | | | | | | Date of Birth/Data Urodzenia: | | | | | | | | | | | dd | | | / | mm | | | | / | | yyyy | | |
| Name of GP/Imię i Nazwisko Lekarz: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| GP Practice Name & address / Nazwa i adres przychodni: | | |  | | | | | | | | | | | | | | | | | | | | Tel. No. / Nr. Tel: | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | |
| Next of Kin contact details in case of emergency/ Kontakt telefoniczny do krewnego w razie potrzeby: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full Name/Imię i Nazwisko: | | | | | | | | | |  | | | | | | | | | Tel. No. / Nr. Tel | | | | | | | |  | | | | | | | | | | | | |
| Full Name/Imię i Nazwisko: | | | | | | | | | |  | | | | | | | | | Tel. No. / Nr. Tel | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have any allergies especially where an anaphylactic shock could occur?/Czy cierpisz jakiekolwiek alergie/uczulenia szczególnie, które mogą wywołać wstrząs anafilaktyczny? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak  No/Nie | | | | | | |
| Type of allergen/  Rodzaj alergenu/uczulenia: | | | | | | | | | | | Name of allergen/  Nazwa alergenu: | | | | Symptoms/Objawy: | | | | | | | Course of action to reduce symptoms/ Działania w celu zmniejszenia objawów: | | | | | | | | | | | | | | | | | |
| Drug (especially if an antibiotic)/Lekarstwo (szczególnie antybiotyk) | | | | | | | | | | |  | | | |  | | | | | | |  | | | | | | | | | | | | | | | | | |
| Food (especially eggs or nuts)/Żywność (szczególnie jajka lub orzechy) | | | | | | | | | | |  | | | |  | | | | | | |  | | | | | | | | | | | | | | | | | |
| Other (e.g. insects, pollen, plasters)/Inne (np. owady, pyłek, plastery/opatrunki) | | | | | | | | | | |  | | | |  | | | | | | |  | | | | | | | | | | | | | | | | | |
| Please ensure you note any medication taken to reduce severity of allergic reaction. If you have a prescribed Adrenalin/Epipen it is essential you discuss and establish with the camp leaders an action/storage plan. Please supply two Adrenalin/Epipens./Proszę podać szczegóły leków, których celem jest zmniejszenie reakcji alergicznej. Jeśli posiadasz przepisany Adrenalin/Epipen, jest konieczne abyś omówił i ustalił z komendą plan użycia i przechowywania leku. Proszę przywieź dwa Adrenaliny/Epi-pens. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have any dietary requirements? / Czy masz wymagania dietetyczne? (e.g. vegitarian, gluten free, lactose free or other/ n.p. jarosz, bezglutenowe, bez laktozy itp.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | No/Nie | | | | |
| If Yes, please provide details/Jezeli tak proszę podaj szczegóły: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Have you been in contact with any contagious disease within the last two weeks? /  Czy miałeś/aś o kontakt z jakakolwiek zaraźliwą chorobą w ciągu ostatnich dwóch tygodni? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | No/Nie | | | | |
| If Yes, please provide details/Jezeli tak proszę podaj szczegóły: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Have you been vaccinated for Tetanus? / Czy byłeś szczepiony przeciw tężcowi? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | No/Nie | | | | |
| If Yes, please provide date of last shot /Jezeli tak proszę podaj date ostatniej szczepionki: | | | | | | | | | | | | | | | | | | | | | | | | | | | dd | | | / | mm | | | | / | | yyyy | | |
| Do you suffer from any medical condition and/or have additional needs? /  Czy masz jakiekolwiek problemy zdrowotne i/lub specyficzne potrzeby? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | No/Nie | | | | |
| If Yes, please provide details/Jezeli tak proszę podaj szczegóły: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | |
| Medical condition/ problemy zdrowotne: | | | | | | | | | | | | Details/Szczegóły: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Do you take any **prescribed medication**/Czy zażywasz **leki przepisane przez lekarza**? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | No/Nie | | | | |
| If Yes, please provide details/Jezeli tak proszę podaj szczegóły: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | |
| Medication/Leki: | | | | | | Dosage/Dawka: | | | | | | | Frequency/Częstotliwość: | | | | Storage/Przechowywanie: | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| If you are unable to look after your own medication please consult with the camp first aider, who will be able to support you. Please bring sufficient medication to include an extra 3 days in case of emergency. **Please ensure your medication is labelled with your name & details of administering the medication** /Jeżeli nie dajesz sobie sam/sama rady z stosowaniem leków proszę porozmawiać z sanitariuszem, który będzie mógł udzieli pomocy. Proszę przywieźć wystarczającą ilość lekarstw na dodatkowe 3 dni w razie wszelkiej potrzeby. **Lekarstwa muszą być oznakowane twoim imieniem i szczegółami stosowania leków.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If need be, I confirm that I will be willing to take the following or similarmedication whilst at camp/ W razie potrzeby potwierdzam, że jestem gotowy/a przyjąć następujące lub podobne lekarstwa podczas akcji noclegowej. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicine/Lekarstwo: | | | | Possible reason/Powód: | | | | | | | | | | | | | | | | | Agreement/Pozwolenie: | | | | | | | | | | | | | | | | | | |
| Paracetamol /Calpol | | | | Headache, temperature, pain (Ból głowy, podwyższona temperatura, ogólny ból) | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| Ibuprofen | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| Stugeron | | | | Travel sickness (Choroba lokomocyjna) | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| Dioralyte | | | | Diarrhoea, vomiting (Biegunka, wymioty) | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| Imodium | | | | Diarrhoea (Biegunka) | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| Clarytin (Antihistamine) | | | | Stings, bites (Użądlenie, ukąszenie) | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| Anthisan Cream | | | | Stings or bites (Użądlenie, ukąszenie) | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| Arnica Cream | | | | Bruising (Siniaczenie) | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | | | No/Nie | | | | | | | |
| **Requirements related to illness / Wymagania dotyczące chorób:**  In order to keep participants of overnight events safe, any adult participants exhibiting symptoms of any illness, prior to the start of the evert, are not take part in the overnight event until fully recovered.  Aby zapewnić bezpieczeństwo uczestników akcji noclegowych, dorośli uczestnicy wykazujący objawy jakiejkolwiek choroby, przed rozpoczęciem akcji, nie mogą brać udziału w akcji noclegowej aż w pełni nie wyzdrowieją.  Signing the declaration below I understand that PSA UK Region insurance does not cover illness related issues.  Podpisując niniejszą deklaracje rozumiem, że ubezpieczenie PSA UK Region nie obejmuje kwestii związanych z zachorowaniem. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other relevant health or dietary information, e.g. recent injuries, illness, Inne uwagi, odnosnie zdrowia czy dietetyczne np. niedawne urazy, choroby | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I declare that I am in satisfactory health to take part in the scout camp.**   * **I agree to receiving emergency medical/dental treatment, including anaesthetics as considered necessary by the medical authorities present.** * **I understand that every attempt will be made to reach the emergency number listed on this medical form.** * **I accept full responsibility for any consequences resulting from non-disclosure of any personal health information.**   **Stwierdzam, że stan moje go zdrowia pozwala na wzięcie udziału w akcji noclegowej.**   * **Zgadzam się w razie potrzeby, na niezbędne leczenie medyczne/dentystyczne w tym także środki znieczulające, jeżeli w opinii lekarskiej to będzie konieczne.** * **Rozumiem, że w razie potrzeby komenda dołoży wszelkich starań, aby skontaktować się z krewnym/wskazaną osobą.** * **Przyjmuję pełną odpowiedzialność za skutki spowodowane nieujawnieniem jakichkolwiek informacji zdrowotnych.**   (The medical form is signed personally by participants over 18 years old)  (Kartę zdrowia podpisuje osobiście uczestnik powyżej 18 lat) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Podpis/Signature**: | | | | | | | |  | | | | | | | | | | **Data/Date**: | | | | | | dd | | | **/** | | mm | | | | **/** | | | yyyy | | |
|  | Please print your name/ proszę wpisz swoje imię i nazwisko drukiem | | | | | | | |  | | | | | | | | | |  | | | | | |  | | |  | |  | | | |  | |  | | |  |
|  |  | | | | | | | | | |  | | | | | |  | | |  | |  | | | |  | |  | | |  |
|  |  | | | | | | | | | |  | | | | | |  | | |  | |  | | | |  | |  | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |