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| 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 | | | | | | | | | | | | | | | | |  | | | |  | |  | | | |  | |  | | |
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| **Parental Declaration and Medical Form for overnight event**  **Stwierdzenie Rodziców 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child’s Surname/Nazwisko dziecka: | | | | | | | | | | | | |  | | | | | | | | Given Name/Imię: | | | | | | | |  | | | | | | | | | | | |
| Home Address/ Adres zamieszkania: | | | | | | | |  | | | | | | | | | | | | | | | | | Tel. No. / Nr. Tel | | | | |  | | | | | | | | | | |
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| Contact details of parents/guardians / Kontakt telefoniczny do rodziców/opiekunów: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full Name/Imię i Nazwisko: | | | | | | | | | |  | | | | | | | | | Tel. No. / Nr. Tel | | | | | | |  | | | | | | | | | | | | | | |
| Full Name/Imię i Nazwisko: | | | | | | | | | |  | | | | | | | | | Tel. No. / Nr. Tel | | | | | | |  | | | | | | | | | | | | | | |
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| Emergency contact details for the duration of the camp/Kontakt telefoniczny w czasie akcji noclegowej: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full Name/Imię i Nazwisko: | | | | | | | | | |  | | | | | | | | | Tel. No. / Nr. Tel | | | | | | |  | | | | | | | | | | | | | | |
| Is the child 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 dziedzko posiada 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 the parents or guardian will need to arrange payment for any medical care the child receive.  Jeśli nie, to rodzice lub opiekun będą musieli zorganizować opłatę za opiekę medyczną otrzymaną przez dziecko. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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: | | | | | |  | | | | | | | | | | |
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| Does your child have any allergies especially where an anaphylactic shock could occur?/Czy dziecko ma 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 your child has a prescribed Adrenaline/Epi-pens it is essential you discuss and establish with the camp leaders an action/storage plan. Please supply two Adrenaline/Epi-Pens./ Proszę podać szczegóły leków, których celem jest zmniejszenie reakcji alergicznej. Jeśli dziecko ma przepisany Adrenalina/Epi-pen, jest konieczne omówić i ustalić z komendą plan użycia i przechowywania leku. Proszę przekazać dwa Adrenaliny/Epi-pens. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Does your child have nightmares/Czy dziecko ma koszmary? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | No/Nie | | | | |
| Does your child sleepwalk/Czy dziecko chodzi we śnie? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | No/Nie | | | | |
| Does your child wet the bed/Czy dziecko moczy się podczas snu? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | No/Nie | | | | |
| Does your child suffer from travel sickness/Czy dziecko ma chorobę lokomocyjną? | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | | No/Nie | | | | |
| Does your child have any dietary requirements/Czy dziecko ma 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | |
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| Has your child been in contact with any contagious disease within the last two weeks? /  Czy dziecko miało kontakt z jakąkolwiek zaraźliwą chorobą w ciągu ostatnich dwóch tygodni? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | No/Nie | | | | |
| If Yes, please provide details/Jezeli tak proszę podaj szczegóły: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | |
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| Has your child been vaccinated for Tetanus? / Czy dziecko było szczepione przeciw tężcowi? | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes/Tak | | | | | | | | No/Nie | | | | |
| If Yes, please provide date of last shot /Jezeli tak proszę podaj date ostatniej szczepionki: | | | | | | | | | | | | | | | | | | | | | | | | | | dd | | | | | / | | mm | | | / | | yyyy | | |
| Does your child suffer from any medical condition and/or have additional needs? /  Czy dziecko ma 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Does your child take any **prescribed medication**/  Czy dziecko 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: | | | | | | | | | | | | | | | | | | | | | | |
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| All medication must be handed over to the camp first aider, who will ensure that correct dosages are given. Please supply sufficient medication to include an extra 3 days in case of emergency. **All medication must be labelled with your child’s name & details of administering the medication.** /Wszystkie lekarstwa należy przekazać sanitariuszowi, który dopilnuje odpowiednie ich stosowanie. Proszę dostarczyć wystarczającą ilość lekarstw na dodatkowe 3 dni w razie wszelkiej potrzeby. **Lekarstwa muszą być oznaczone imieniem dziecka i szczegółami stosowania leków.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If need be, I give permission for my child to be given the following medication or similar whilst at camp: / W razie potrzeby pozwalam, aby dziecko otrzymało 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 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, 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 information concerning your child, e.g. recent injuries, illness, issues at home, etc /Inne uwagi rodziców dotyczące dziecka, np. niedawne urazy, choroby, uwaga rodzinna itp: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **I declare that my child’s health is satisfactory to allow him/her to take part in the scout overnight event, and having full confidence in the camp leaders, I allow my child to take part in all activities and exercises in the camp plan.**   * **I give permission for my child to be transported for medical attention by a scout leader.** * **I agree to my child receiving emergency medical/dental treatment as considered necessary by the medical authorities.** * **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 health or psychological information about my child.**   **Stwierdzam, że stan zdrowia mego dziecka jest zadawalający do wzięcia udziału w akcji noclegowej i mając pełne zaufanie do komendy, pozwalam memu dziecku na udział we wszystkich zajęciach i ćwiczeniach przewidzianych w programie obozu.**   * **Daję pozwolenie, aby w razie potrzeby członek komendy zawiózł moje dziecko na konsultację lekarską.** * **Zgadzam się, aby w razie nagłej potrzeby moje dziecko otrzymało niezbędne leczenie medyczne/dentystyczne, które w opinii lekarskiej jest uznane jako konieczne.** * **Rozumiem, że w razie potrzeby komenda dołoży wszelkich starań, aby skontaktować się z rodzicem/wskazaną osobą wymienionym w tym formularzu.** * **Przyjmuję pełną odpowiedzialność za skutki spowodowane nieujawnieniem jakichkolwiek informacji zdrowotnych lub psychologicznych dotyczących mojego dziecka.**   (The medical form is signed personally by participants over 18 years old)  (Kartę zdrowia podpisuje osobiście uczestnik powyżej 18 lat) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **Podpis/Signature**: | | | | | | | |  | | | | | | | | | | **Data/Date**: | | | | | | dd | | **/** | | | mm | | | | | **/** | | | yyyy | | |
|  | Choose an item.\* | | | | | | | |  | | | | | | | | | |  | | | | | |  | |  | | |  | | | | |  | | |  | | |
|  | Please print your name/ proszę wpisz swoje imię i nazwisko drukiem | | | | | | | |  | | | | | | | | | |  | | | | | |  | |  | | |  | | | | |  | |  | | |  |
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| (\*Please choose as appropriate/Proszę wybierz odpowiednie) | | | | | | | | | | | | | | | | | | |  | | | | | |  | |  | | |  | | | | |  | |  | | |  |