CHECKLIST OF FORMS

☐ CODE OF CONDUCT
All campers must complete this form. Failure to follow the code of conduct can result in dismissal from camp.

Health Information Forms
There are 4 pages to this set of information.

☐ Page 1
☐ Page 2
☐ Page 3
☐ Page 4
☐ Copy of Insurance Card

☐ Medicine Turn-in
Campers only need this form if you are turning in medication to be given to camper on a daily basis by Nurse.

☐ Waiver and Consent Form

Please return all completed forms except for the packing list to

Druhna Christine Puskar
Polish Falcons of America
381 Mansfield Avenue
Pittsburgh, PA 15220

If you have any questions you can email Druhna Chris at:
cpuskar@polishfalcons.org
or call her toll free at 1-800-535-2071

Polish Falcons of America

Camp Code of Conduct and Camp Information

This form is required for ALL campers and Junior Counselors.

Camper's Name: _____

Additional Campers in Family: _____

Additional Campers in Family: _____

Camp Code of Conduct

I understand that my attitude and behavior are critical to the success of the camping session; therefore, for the good of the camp, as well as my fellow group members, I agree to abide by the following:

1. I will cooperate with the camp staff and be sensitive to the needs of my fellow campers.
2. I will participate in program activities as well as camp kapers (chores) and clean up.
3. I will respect the people and places with which I come in contact.
4. I will show respect for myself and others by being responsible for my words and actions toward other campers and the camp staff. I understand that teasing, intimidating, and bullying other campers is not acceptable behavior.
5. I understand that the use of tobacco, alcohol, drugs, and inappropriate language or subject matter will not be tolerated and that usage will result in dismissal from camp.
6. I understand that I am not allowed to bring weapons or fireworks to camp.
7. I understand that I am not allowed to bring food to camp.
8. I will be responsible for my personal belongings and equipment and will not hold the PFA responsible for their loss or damage due to my negligence or neglect.
9. I will treat equipment provided by the St. Vincent DePaul Society and the PFA with care. I understand that I will be assessed for damages to such equipment in the event that my use of it is negligent or abusive.
10. I understand that I am expected to dress appropriately and follow all directions for camp activities. If I do not dress appropriately, I will be asked to sit out for my own safety and the safety of my peers.
11. I understand that I am I may bring electronic devices but that I will not be allowed to use them during camp activities. They may be used during rest periods in cabins. If you bring your electronic devices with you during activities, they will be taken and returned at the end of the day. The 3rd time the device is taken, it will be returned at the end of the week.
12. I will observe all safety rules and regulations established for program, recreational, and personal activities. I will report all injuries or illnesses to the camp staff.

13. I understand that if I am invovled in any unacceptable behavior, I will receive 2 warnings. After two warnings, my parents/guardians will be called and I will be sent home. I understand that if I am sent home it will be my parents/guardians responsibility to pick me up at any time of the day or night and that any additional expense incurred will be their responsibility.

I have reviewed the Code of Conduct with my camper and understand, agree with and fully accept the above, as outlined for camp participation.

Parent/guardian signature: _____

I understand, agree with, and fully accept the above Code of Conduct and Camp Information.

1st Camper Signature: _____

2nd Camper Signature: _____

3rd Camper Signature: _____

Date: _____

Health History Form

Name of Camper _____

Address _____

_____

Gender _____ M _____ F Date of Birth _____ Age as of June 1

Custodial Parent/Guardian: _____

Day Phone _____ Evening Phone _____

In case of emergency when parent/guardian is not available, please notify

Name _____ Relationship to camper

Day Phone _____ Evening Phone _____

Email Address: _____

Insurance Information

Is participant covered by family medical/hospital insurance _____ Y _____ N

If so, indicate the carrier plan name: _____

Carrier Address _____

Name of Insured _____ Relationship to Participa

PLEASE INCLUDE A COPY OF THE INSURANCE CARD

IMPORTANT: The following information must be complete for camp attendance.

Permission to Provide Necessary Treatment or Emergency Care: I hereby give my permission to medical personnel selected by Polish Falcons of America to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Polish Falcons of America to secure and administer treatment, including hospitalization, for the person named above. This health history is correct and complete as far as I know and the person herein described has permission to engage in all program activities except as noted. This completed form may be photocopied.

Signature of parent: _____

Witness: _____ Date:

I also understand and agree to abide by the restrictions placed on my activities.

Signature of minor: _____ Date:

Health History

The following must be filled in by the parent/guardian. The intent of this information is to provide health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health care personnel.

ALLERGIES: List all known. Describe reaction and management to reaction

Medication Allergies

Food Allergies

Environmental Allergies

Medications being taken

Please list all medicatons (including over-the-counter or non-prescription drugs) taken currently. Bring enough medication to last the entire time at camp. Keep in the original packaging/bottle that identifies the prescribing physician, (if prescription drug), the name of the medication, the dosage and the frequency of administration. Use additional sheet of paper if needed.

_____ This person takes NO medications on a routine basis. _____ This person takes medications as follows:

Medication		Dosage		Specific times taken each day	
Reason for taking:					
Medication		Dosage		Specific times taken each day	
Reason for taking:					
Medication		Dosage		Specific times taken each day	
Reason for taking:					
Medication		Dosage		Specific times taken each day	
Reason for taking:					

Restrictions - The following restrictions apply to this individual.

DIETARY

_____ Does not eat red meat _____ Does not eat pork _____Does not eat eggs

_____ Does not eat seafood _____ Does not eat poultry _____Does not eat dairy products

Other: _____

Restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Illnesses/Diseases/Health Conditions (Check all that apply.)

Asthma		Braces/Retainer	
Colds-Frequent		Ear Infections-often	
Measles		Contacts/glasses	
Hepatitis		Hearing Imapirment	
Nosebleeds		Epilepsy/Seizures	
Bed Wetting		Sleep Disorder	
Diabetes		Eating disorder	
Heart Disease		Headaches-often	
HIV/Aids		Menstrual cramps	
Stomach upset		Sore throats-often	
Bleeding disorder		Chicken pox	
Tuberculosis		Fainting	
German Measles		Mumps	
Hypertension		Mononucleosis	
Rheumatic Fever		Migraines	

Please explain any checks:

Any operations or serious health problems or hospitalizations:

Immunization Record

Date of Last Tetanus: _____ Date of last Physical: _____

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD Tetanus/diptheria						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus Influenza B						
Hepatitis B						
Varicella (Chicken pox)						
BCG						

Name of Family Physician: _____ Phone: _____

Address: _____

Name of family dentist/orthodontist: _____ Phone: _____

Address: _____

PERMISSION TO DISPENSE MEDICATIONS

Parents/Guardians: Please read this list of medications and symptoms carefully. These medications and the symptoms for which they are administered are approved by a licensed physician and may be administered by the camp Health Care Manager. Use this information to determine which medications you give permission to be dispensed to your child/ward. All of these medications are stocked in the camp Health Care Station.

Initials	Medication	Symptoms
	Advil	menstrual pain, sprain, strain, fever
	AloeVera Gel	sunburn
	Benadryl tabs	severe itching, swelling from insect bites, hives, rashes, poison ivy, etc.
	Calamine lotion	insect bites
	Tums/Maalox	indigestion, stomach ache
	Tylenol	pain, fever, flu
	Artificial tears	eye irritation
	Ben Gay	muscle aches/strains
	Orajel	toothache
	Cough drops	cough/sore throat
	Imodium	diarrhea
	Laxative	constipation
	Chloroseptic spray	sore throat
	Robitussin	cough

Any other information you deem necessary for us to know to protect the health and welfare of your child while at Polish Falcons of America National Camp.

Medicine Turn-in

Bring to camp Check-in

Need only if turning in medicine. If not turning in medicine, disregard this form.

Camper Name: _____

Please mark with amount of liquid or # of pills to be given.

Medication	Purpose	As Needed	Breakfast	Lunch	Dinner	Before bed	Other

Any changes in camper's health since the medical form was filled out: _____

_____

_____

_____

Any information we should know about your child to help their stay at camp be safe and more enjoyable? _____

_____

_____

_____

_____

Parent Signature: _____

Date: _____

YOUTH WAIVER AND CONSENT FORM

I, the parent or guardian of this athlete, hereby agree to allow him/her to participate in the activity designated below.

I understand that there are certain risks of injury inherent in the practice and play of this activity, as well as in traveling and other related activities incidental to his/her participation, and I am willing to assume these risks for my child. I hereby certify that my child is fully capable of participating in the designated activity and that my child is healthy and has no physical or mental disabilities or infirmities that would restrict full participation in these activities, except as listed below.

I hereby certify that my child does not have a concussion and has not been in the care of a health professional for a concussion in the past year. _____YES _____NO
If no is checked, please include a copy of your child's release from a health care professional to participate in physical activities such as this event.

In addition to giving my full consent for my child's participation, I do hereby waive, release, and hold harmless the Polish Falcons of America, its officers, coaches, sponsors, supervisors, and representatives for any injury that may be suffered by my child in the normal course of participation in the designated activities incidental thereto, whether the result of negligence or any other cause.

Polish Falcons of America National Youth Camp
June 26 – July 3, 2016 * Angola, NY

Name of Participant: _____

Participant Email Address: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Telephone: _____ Age: _____

Please list any physical limitations (allergies, hearing, vision, etc.)

_____

_____

Parent Signature: _____

Parent Email Address: _____

The Polish Falcons of America reserves all rights to photographs and videos taken during this event which will be used solely to promote the mission of the PFA including our printed publications and our website. Participants agree to allow the PFA to use photographs and videos in which they appear.

I have read and understand the above:

Participant Signature: _____

POLISH FALCONS OF AMERICA
THE STRONG, FRIENDLY, FAMILY FRATERNAL