

**NOTICE**

**THIS DOCUMENT IS AN AUTHORIZATION, CONSENT AND RELEASE FORM.** Upon enrollment, the information requested below is required to provide a medical provider an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the NSCC/NLCC training program. Also this information will be provided to a medical provider in case of injury or illness while participating in NSCC/NLCC activities. **If taking medications at time of enrollment, list in Block 9.**

**THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE.** You are encouraged to consult your private medical provider regarding past illnesses. Proof of immunization for polio, measles, mumps, rubella, hepatitis B, pertussis and tetanus plus diphtheria and Menactra vaccine for Meningitis must be attached.

After enrollment, use this form to screen cadets for continued medical fitness before sending to Orientation, Recruit, Advanced and/or other trainings.

Commanding Officers (CO) and Commanding Officers of Training Contingents (COTC) retain the obligation to deny acceptance for enrollment or training to any cadet if upon review of this form, it is determined that the cadet is not physically/medically qualified for participation unless Medical Condition and/or disability accommodation per ADA guidelines has been requested and approved.

**1. UNIT INFORMATION**

<b>1a. Unit Name</b>	<b>1b. Region</b>
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**2. PERSONAL INFORMATION**

<b>2a. Last Name</b>	<b>2b. First Name</b>	<b>2c. MI</b>	<b>2d. USNSCC ID Number</b>
<b>2e. Age</b>	<b>2f. Date of Birth (DD MMM YY)</b>	<b>2g. Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>2h. Parent/Guardian Name</b>
<b>2i. Home Address</b>	<b>2j. City</b>	<b>2k. State</b>	<b>2l. Zip Code + 4</b>
<b>2m. Primary Phone</b>	<b>2n. Alternate Phone</b>	<b>2o. Date of Last Physical Examination (DD MMM YY)</b>	

**3. MEDICAL PROVIDER/INSURANCE INFORMATION**

<b>3a. Medical Insurance Provider Name</b>	<b>3b. Medical Insurance Policy Number</b>
<b>3c. Medical Insurance Provider Address</b>	<b>3d. Medical Insurance Provider Phone</b>
<b>3e. Medical Provider Name</b>	<b>3f. Medical Provider Phone Number</b>

**4. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 9: explain treatment to return cadet to medically fit for NSCC)**

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO
<b>4a.</b> Tuberculosis or live with someone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>4n.</b> Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>
<b>4b.</b> Chronic or recurrent abdominal or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>4o.</b> Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	<input type="checkbox"/>
<b>4c.</b> Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<b>4p.</b> Car, train, sea, and/or air sickness	<input type="checkbox"/>	<input type="checkbox"/>
<b>4d.</b> Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	<b>4q.</b> A period of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
<b>4e.</b> Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<b>4r.</b> Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>
<b>4f.</b> Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<b>4s.</b> Received counseling for emotional or behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>
<b>4g.</b> Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	<b>4t.</b> Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>
<b>4h.</b> Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	<b>4u.</b> Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
<b>4i.</b> Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	<b>4v.</b> Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
<b>4j.</b> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<b>4w.</b> Been hospitalized ( <i>if yes, why, when, where</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>4k.</b> Anemia (including sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>	<b>4x.</b> Any illness or injury not mentioned above ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>4l.</b> Dizziness or fainting spells (including after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<b>4y.</b> Advised to avoid certain physical activities ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>4m.</b> Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b>4z. FEMALES ONLY:</b> At what age did you begin menstrual cycle:		

## REPORT OF MEDICAL HISTORY

**5. IMMUNIZATION RECORDS** (attach copy of immunization record to this form)

<b>5a.</b> Date of last tetanus or booster	<b>5b.</b> Date of Menactra Vaccine for Meningitis	<b>5c.</b> Date of negative PPD or Medical Provider Clearance for TB
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**6. ALLERGIES** (Mark each item "YES" or "NO". Every item marked yes must be fully explained in Block 9.)

DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	YES	NO		YES	NO
<b>6a.</b> Bee or wasp sting	<input type="checkbox"/>	<input type="checkbox"/>	<b>6e.</b> Latex	<input type="checkbox"/>	<input type="checkbox"/>
<b>6b.</b> Hay Fever or seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<b>6f.</b> Any drug, e-mycin antibiotic, or sulfa allergies, list in Block 9	<input type="checkbox"/>	<input type="checkbox"/>
<b>6c.</b> Insect bites	<input type="checkbox"/>	<input type="checkbox"/>	<b>6g.</b> Other allergies, list in Block 9	<input type="checkbox"/>	<input type="checkbox"/>
<b>6d.</b> Iodine/seafood	<input type="checkbox"/>	<input type="checkbox"/>	<b>6h.</b> Food allergies, list in Block 9	<input type="checkbox"/>	<input type="checkbox"/>

**7. OVER THE COUNTER MEDICATIONS** (These medications may be administered by our staff when requested)

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|-------------------------|--|
| 1. Allergies:           | Benadryl   |
| 2. Colds:               | Cough Medicine (Robitussin DM, Dimetapp, etc.), Throat/Cough Drops (Chloraseptic, Halls, etc.), Decongestant (Sudafed, etc.) |
| 3. Constipation:        | Milk of Magnesia, Dulcolax, Ex-Lax, or Glycerin Suppository  |
| 4. Cuts and Scraps:     | Bacitracin ointment, Betadine, Neosporin ointment  |
| 5. Diarrhea:            | Pepto Bismol, Kaopectate, Imodium AD, etc.   |
| 6. Headache             | Tylenol or Ibuprofen (Motrin, Advil, Aleve)  |
| 7. Indigestion:         | Calcium Carbonate (Tums, Rolaids, etc.)  |
| 8. Itch/Rash:           | Cortisone Cream or Calamine Lotion   |
| 9. Sea/Motion Sickness: | Dramamine, Bonine, etc.  |
| 10. Sprains:            | Acetaminophen (Tylenol) or Ibuprofen (Motrin, Advil, Aleve)  |
| 11. Sunburn:            | Calamine Lotion, Topical Lidocaine Spray or Aloe Vera Gel  |
| 12. Wounds:             | Bacitracin ointments, Betadine, Neosporin Ointment   |

***Other medications not listed above may be administered if so recommended by qualified medical staff.  
Parents will be contacted directly when over the counter medications need to be administered during unit drills***

**8. STATEMENT OF UNDERSTANDING AND CONSENT**

BY INITIALING YOU CERTIFY YOUR UNDERSTANDING & CONSENT TO THE FOLLOWING PARAGRAPHS:

Parent/Guardian  
Initial Below

**8a.** I understand that all medications will be administered to the cadet based on dosing instructions on the medication bottle/package. In no instance will cadets be allowed to self-medicate with any over the counter medication.

**8b.** I understand and consent that these written instructions may be superseded if, in the opinion of a medical provider, not doing so would place the cadet in a medically compromised condition.

**8c.** I understand that if I do not want my child to be administered over the counter medications, or certain medications concurrent with other medications, I must specify those medications or write, **"Do not medicate my child with any over the counter medications"** in Block 9.

**9. REMARKS** (please include comments as required by Blocks 4, 6, and/or 8. Also provide any other medical history that you or your physician deems important)

**10. AUTHORIZATION AND RELEASE**

I certify that, to the best of my knowledge, the information provided is true and accurate and I have disclosed all pertinent medical history. Furthermore, I authorize the Naval Sea Cadet Corps, its agents, officials, and training staff members, to dispense medication listed on this Authorization. I "Hold Harmless" the Naval Sea Cadet Corps from any and all liability, actions, or causes of action for damages or injury that may arise, directly or indirectly, from my child's use of medication while participating in Naval Sea Cadet Corps Activities. I understand that training staff members may not be medical professionals and that medication will be dispensed according to the manufacturer's instructions and/or the instructions I provided on this authorization.

<b>10a.</b> Parent/Guardian Name (Type or Print)	<b>10b.</b> Signature	<b>10c.</b> Date (DD MMM YY)
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