

<b>U.S. NAVAL SEA CADET CORPS</b> <b>U.S. NAVY LEAGUE CADET CORPS</b>	<b>CADET APPLICATION</b> <b>MEMBER INFORMATION</b>	<i>FOR OFFICIAL USE ONLY</i>	
<b>INSTRUCTIONS</b>			
1. Please print or type only with black ink. 2. Fill in all blocks that apply; for those that do not, enter "Not Applicable" or "N/A" 3. Endorsement of all agreements and releases is required to continue the enrollment process. 4. Application should be reviewed on a regular basis to ensure currency of information. 5. A new application must be completed upon transfer from the NLCC to the NSCC.			
<b>1. APPLICANT INFORMATION</b>			
<b>1a.</b> Last Name	<b>1b.</b> First Name	<b>1c.</b> Middle Name	<b>1d.</b> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>1e.</b> Home Address	<b>1f.</b> City	<b>1g.</b> State	<b>1h.</b> Zip Code + 4
<b>1j.</b> Date of Birth (DD MMM YY)	<b>1k.</b> Primary Phone	<b>1l.</b> E-Mail Address	
<b>1m.</b> Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes grade:</i>	<b>1n.</b> School Name & City		<b>1o.</b> GPA
<b>1p.</b> Has the applicant ever been charged <b>OR</b> convicted of a criminal offense? <i>(use an additional sheet if necessary)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes please explain:</i>			
<b>1q.</b> Citizenship <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident - Registration Number:		<b>1r.</b> Referred/Recruited by (Cadet Name, if applicable)	
<b>2. APPLICANT PROMISE</b>  <i><b>I promise to serve faithfully, honor our flag, abide by Naval Sea Cadet Corps Regulations, carry out the orders of the officers appointed over me, and so conduct myself as to be a credit to myself, my unit, the U.S. Naval Sea Cadet Corps, the Navy, the Coast Guard, and my country. So help me God.</b></i>			
<b>2a.</b> Applicant Signature			<b>2b.</b> Date (DD MMM YY)
<b>3. PRIMARY PARENT/LEGAL GUARDIAN INFORMATION</b> <i>(will be listed as next of kin and first contact in case of an emergency)</i>			
<b>3a.</b> Name		<b>3b.</b> Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	
<b>3c.</b> Address	<b>3d.</b> City	<b>3e.</b> State	<b>3f.</b> Zip Code + 4
<b>3g.</b> Primary Phone	<b>3h.</b> Alternate Phone	<b>3i.</b> E-Mail Address	
<b>4. SECONDARY PARENT/LEGAL GUARDIAN CONTACT INFORMATION</b>			
<b>4a.</b> Name		<b>4b.</b> Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	
<b>4c.</b> Address	<b>4d.</b> City	<b>4e.</b> State	<b>4f.</b> Zip Code + 4
<b>4g.</b> Primary Phone	<b>4h.</b> Alternate Phone	<b>4i.</b> E-Mail Address	
<b>5. EMERGENCY CONTACT INFORMATION</b> <i>(will be contacted in case primary or secondary contacts are unreachable in case of an emergency)</i>			
<b>5a.</b> Name		<b>5b.</b> Relationship <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Family Friend	
<b>5c.</b> Address	<b>5d.</b> City	<b>5e.</b> State	<b>5f.</b> Zip Code + 4
<b>5g.</b> Primary Phone	<b>5h.</b> Alternate Phone	<b>5i.</b> E-Mail Address	
<b>6. DEMOGRAPHICS</b>			
<b>6a.</b> Ethnicity <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Black (Non-Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaskan Eskimo <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline to State			
<b>6b.</b> Community Profile <input type="checkbox"/> Inner City <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural <input type="checkbox"/> Other <input type="checkbox"/> Decline to State			

## CONSENT AND RELEASE OF LIABILITY BY PARENT/GUARDIAN

### 8. PARENT/LEGAL GUARDIAN AGREEMENT & CONFIRMATION

I hereby consent to my child/ward enrolling in the U.S. Naval Sea Cadet Corps (USNSCC). I understand that the USNSCC is organized along military lines, that USNSCC regulations govern my child's/ward's membership, and that violation of said regulations may result in my child's/ward's discharge from the USNSCC. I will ensure that my child/ward abides by all regulations and lawful orders from superior officers and cadets. I certify that, to the best of my knowledge, he/she is physically and mentally fit to take part in vigorous activities, I have disclosed all physical/medical/disability limitations, and he/she is not suffering from any communicable disease. I further agree to be responsible for the value of any uniforms and/or equipment loaned him/her, reasonable wear and tear expected. I understand that such uniforms or equipment shall remain the property of the USNSCC while on loan, and I agree to return them when my child/ward ceases to serve as a cadet, or at any other time upon request of a USNSCC officer or other authorized agent. I have been briefed on the USNSCC medical insurance plan. I am aware this is an accident/illness "excess" policy and that the limit of the policy is a total of \$25,000 for all accidental benefits/\$5,000 for illness with no deductible. I understand that my personal medical insurance is the primary policy, but in the event that I do not have insurance and/or the USNSCC policy limits are exhausted, I understand that I am responsible for all medical payments above \$25,000 for accidents/\$5,000 for illnesses. I also understand that payment of enrollment fees will be required ANNUALLY, and payment of uniform fees may be required upon enrollment. I agree, on my child/ward's behalf, that he/she will be bound by all USNSCC regulations, policies, and amendments thereto that govern his/her membership and conduct; I further waive any right to challenge in any way any determination made by the USNSCC regarding my child's/ward's continuance of membership in the USNSCC should he/she violate said regulations.

8a. Signature of Parent/Legal Guardian

8b. Date (DD MMM YY)

8c. Signature of Witness (Unit CO or other designated officer)

### 9. STANDARD RELEASE

I, being the parent/legal guardian of a member of the USNSCC, in consideration of his/her acceptance and continuance of membership in the USNSCC, hereby release from any and all claims, demands, actions, or causes of action due to death, injury or illness the following: (1) the government of the United States of America and all its departments and agencies; (2) any jurisdiction (state, county, city, town, district or other political subdivision) where official USNSCC activities take place; (3) the Navy League of the United States; (4) any organization or association, public or private, that sponsors USNSCC activities; (5) the USNSCC; (6) all officers, representatives, and agents, acting officially or otherwise of the previously mentioned, jurisdictions, organizations, and associations.

I hereby acknowledge that I have received and reviewed the AIG Blanket Special Risk Insurance Binder (Policy SRG 9152960) and the Cincinnati Indemnity Company Liability Policy Certificate (Policy ENP0059849, et. al.) for the U.S. Naval Sea Cadet Corps & affiliated councils within the USA and its territories or possessions.

I hereby consent to the examination and treatment of my child/ward by the medical facilities of the Department of Defense (DOD), U.S. Coast Guard (USCG), National Oceanographic and Atmospheric Administration (NOAA), U.S. Public Health Service (USPHS), or civilian physicians/medical facilities to determine physical status for participation in the USNSCC. I further authorize, as may be required, treatment in said facilities in the event of any illness or accident arising aboard DOD, USCG, or NOAA facilities or vessels, or during other authorized USNSCC activities. This consent includes any medical, anesthesia, or surgical treatment or hospital services rendered under the general and/or special instructions of the attending physician or other physicians assigned his/her care. This consent does not include major surgery unless, in the medical opinion of two physicians, it is reasonably necessary to save life, or where second opinions are similarly impracticable the concurring opinions of other physicians may be excused.

I also grant permission for my child/ward to be transported as a passenger in military aircraft, vessels and vehicles.

I consent to my child/ward being videotaped and/or photographed and to permit the reproduction and/or publication of same, or of any other videotapes or photographs by any photographic facility of the Department of Defense/Coast Guard or by the Navy League of the United States, its regional organization or local councils, or other sponsoring organization, or by the USNSCC or its divisions, or to their use in connection with educational programs or activities of the said organizations, and I further assign to the said organizations all right, title and interest in the above described videotape recordings or photographs for any further use.

This standard release shall remain in effect for the duration of my child/ward's membership in the USNSCC. I also give my permission for facsimiles of this release to be made, and when presented by an authorized official of the USNSCC, DOD, USCG, NOAA shall be considered as valid as the original signed by me.

9a. Cadet Full Name

9b. USNSCC ID Number

9c. Parent/Guardian Name (Print or Type)

9d. Parent/Guardian Signature

9e. Date (DD MMM YY)

9f. Name of Witness (Unit CO or other Designated Officer - Print or Type)

LTJG Samuel Elliott

9g. Signature of Witness (Unit CO or Designated Officer)

9h. Date (DD MMM YY)

#### UNIT USE – DO NOT WRITE BELOW THIS LINE

ENROLLMENT	DATE	DISENROLLMENT	DATE	Unit Name and Drill Location/Address  <b>William E. Taylor Division U.S. Naval Sea Cadet Corps Navy Operational Support Center 250 Airport Road New Castle, DE 19720</b>
Cadet Application and Agreement		ID Card Returned		
Report of Medical History		Uniforms Returned		
Report of Medical Examination		Reason for Disenrollment		
Fees Collected				

**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> William E. Taylor Division	<b>1b. Region</b> 043TAY
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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)**

<b>HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:</b>	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.)

<b>DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
<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)

- |                         |  |
|-------------------------|--|
| 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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**INSTRUCTIONS**

Acceptance criteria for the Naval Sea Cadet Corps/Navy League Cadet Corps (NSCC/NLCC) are listed on the reverse side. No one will be denied admission to the program due to a medical disability, however participation may be limited if the cadet is not able to meet the medical standards necessary to FULLY participate in training activities involving strenuous physical exercise and activities such as orientation in fighting shipboard fires in often hot and humid environments. The medical provider should list any condition(s) that could interfere with full, unrestricted, participation in the NSCC/NLCC. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illnesses, must be listed. The history of immunization should be verified to the satisfaction of the medical provider. A licensed medical provider must complete this examination.

**1. UNIT INFORMATION**

<b>1a. Unit Name</b> <b>William E. Taylor Division</b>	<b>1b. Region</b> <b>043TAY</b>
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**2. PERSONNEL 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 Physical Examination (DD MMM YY)</b>

**3. CLINICAL EVALUATION**

	Normal	Abnormal	NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment)
<b>3a. Head, Face, Neck, and Scalp</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3b. Nose</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3c. Sinuses</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3d. Ears – General (Internal and External Canals)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3e. Drum (Perforation)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3f. Eyes- General</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3g. Ophthalmoscopic</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3h. Pupils (Equality and Reaction)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3i. Heart (Thrust, Size, Rhythm, and Sounds)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3j. Lungs and Chest</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3k. Abdomen and Viscera (Include Hernia)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3l. External Genitalia (Genitourinary)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3m. Upper Extremities</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3n. Lower Extremities</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3o. Feet</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3p. Spine and other Musculoskeletal</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**4. LABORATORY FINDINGS (only required for those with a history of urinary tract infections or anemia, enter N/A if tests were not administered)**

<b>4a. Urinalysis</b> (1) Albumin: _____ (2) Sugar: _____	<b>4b. Blood</b> (1) Hemoglobin: _____ (2) Hematocrit: _____
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**5. MEASUREMENTS AND OTHER FINDINGS**

<b>5a. Height</b> inches	<b>5b. Weight</b> lbs.	<b>5c. Obese</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>5d. Pulse</b>	<b>5e. Blood Pressure</b> (1) Systolic: _____ (2) Diastolic: _____
<b>5f. Audiogram (if available)</b>				<b>5g. Wears Glasses</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HZ</b>	<b>500</b>	<b>1000</b>	<b>2000</b>	<b>3000</b>
<b>Right</b>				
<b>Left</b>				
				<b>5h. Wears Contacts</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
				<b>5i. Uncorrected Vision</b> (1) Left: 20/ _____ (2) Right: 20/ _____
				<b>5j. Color Vision</b>

**5k. Other Findings (if more room is needed, continue on reverse)**

## REPORT OF MEDICAL EXAM

**6. CLINICAL SCREENING** (Please check if the patient has any of the following conditions and whether it will affect the ability to participate in NSCC/NLCC activities.)

Condition(s)	Pre-Existing	NOTES: (Describe every condition in detail. Enter pertinent item number before each comment)
6a. Seizure or convulsion disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6b. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6c. Symptomatic/recurring orthopedic injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6d. Diabetes, Type I	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6e. Diabetes, Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6f. Hypersensitivity to Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6g. Insect bites/stings sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6h. Head injuries resulting in residual impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6i. Neurological Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6j. History of recurring loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6k. History of debilitating motion sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6l. Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6m. Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**7. NOTES, REMARKS, AND OTHER FINDINGS** (Use additional sheets of paper if needed)

**8. MEDICAL PROVIDER ENDORSEMENT** (Check all that apply):

I have reviewed the data above, reviewed the patient's medical history form and make the following recommendations for his/her participation in the NSCC/NLCC

8a.  **CLEARED WITHOUT RESTRICTIONS**

8b.  Cleared **AFTER** further evaluation or treatment for:

8c.  Cleared for **LIMITED** participation

Not cleared for (specify activities):

Cleared only for (specify activities):

Reasons:

8d.  **NOT CLEARED FOR PARTICIPATION**

Reasons:

8e.  **OTHER RECOMMENDATIONS**

Recommend close monitoring during conditioning because of weight/fitness/other.

Recommend restrictions or monitoring of weight loss/gain or fitness concerns.

Recommend participation under following condition(s):

Other:

**9. MEDICAL PROVIDER**

<b>9a.</b> Name of Medical Provider (Type or Print) or Medical Provider Stamp	<b>9b.</b> Signature (MD, DO, NP, PA)	<b>9c.</b> Date (DD MMM YY)		
<b>9b.</b> Medical Provider Address	<b>9c.</b> City	<b>9c.</b> State	<b>10c.</b> Zip Code +4	<b>9c.</b> Phone

**NOTICE**

This form, used as a supplement to the Report of Medical History, is **MANDATORY** for all Cadets who are currently taking medication and will report to training with prescription and/or non-prescription (over the counter) medications. Cadets may bring prescription and non-prescription medication to training as long as the medication is not for a contagious illness or physical condition that would normally preclude his/her full participation in rigorous physical activity. Medication must NOT have expired. This form is to be used in conjunction with the current report of Medical History when screening cadets prior to attending "ALL" trainings for those taking medications.

**THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE.** If the cadet is taking prescription medications, a qualified medical provider must endorse this document in Section 10, confirming the accuracy of the prescription information provided. Medical provider signature for OTC medications is NOT REQUIRED; parent signature is sufficient for OTC medications.

Commanding Officers of Training Contingents (COTC) and Senior Escort Officers (SEO) retain the obligation and right to deny acceptance for training to any Cadet if upon review of the Report of Medical History and this document, it is determined that the Cadet is not physically and/or medically qualified (without ADA accommodation). This includes a determination that they do not have sufficient or qualified personnel to administer required medications. Parents/Legal Guardians should be consulted before making these type determinations.

**1. PERSONNEL INFORMATION**

<b>1a.</b> Last Name	<b>1b.</b> First Name	<b>1c.</b> MI	<b>1d.</b> USNSCC ID Number
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**2. TRAINING INFORMATION**

<b>2a.</b> Training Code	<b>2b.</b> Training Start Date	<b>2c.</b> Training End Date	<b>2d.</b> Training Days 0	<b>2d.</b> Training Location
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**3. PACKAGING AND LABELING REQUIREMENTS**

<b>3a. Prescription Medication</b> <ul style="list-style-type: none"> <li>Must be in the original container from the pharmacy or manufacturer.</li> <li>Must have a complete prescription label attached to the container.</li> <li>The container will only contain the medication it is labeled for.</li> <li>The Cadet must be the person prescribed the medication and his or her name must appear on the prescription label.</li> </ul>	<b>3b. Non-Prescription Medication (Over the Counter)</b> <ul style="list-style-type: none"> <li>Must be in the original container from the manufacturer.</li> <li>Must have a complete manufacturer's label attached to the container identifying the contents and directions for use.</li> <li>The container will only contain the medication it is labeled for.</li> </ul>
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**4. PRESCRIPTION OR NON-PRESCRIPTION MEDICATION** *(Use additional documents if more than three medications are provided)*

<b>4a.</b> Name of Medication	<b>4b.</b> Strength	<b>4c.</b> Total Quantity Required	<b>4d.</b> Total Quantity Sent
<b>4e.</b> Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	<b>4f.</b> Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 4i and/or Block 7		
<b>4g.</b> Prescribing Provider Name	<b>4h.</b> Prescribing Provider Phone Number	<b>4i.</b> Prescribing Provider Phone Number (alternate)	
<b>4j.</b> Reason for medication <i>(Describe in detail if necessary)</i>			
<b>4k.</b> Relevant side effects to be observed if any: <i>(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)</i>			
<b>4l.</b> List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
<b>4m.</b> Expected effects if medication is not taken as directed.			

**5. PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS** *(Use additional documents if more than three medications are provided)*

<b>5a.</b> Name of Medication	<b>5b.</b> Strength	<b>5c.</b> Total Quantity Required	<b>5d.</b> Total Quantity Sent
<b>5e.</b> Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	<b>5f.</b> Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 5i and/or Block 7		
<b>5g.</b> Prescribing Provider Name	<b>5h.</b> Prescribing Provider Phone Number	<b>5i.</b> Prescribing Provider Phone Number (alternate)	
<b>5j.</b> Reason for medication <i>(Describe in detail if necessary)</i>			
<b>5k.</b> Relevant side effects to be observed if any: <i>(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)</i>			
<b>5l.</b> List any other important information about this medication since access to medical information or facilities could be delayed due to training activates or location.			
<b>5m.</b> Expected effects if medication is not taken as directed.			

<b>MEDICAL HISTORY SUPPLEMENTAL</b>			
<b>6. PRESCRIPTION OR NON-PRESCRIPTION MEDICATION</b> <i>(Use additional documents if more than three medications are provided)</i>			
<b>6a.</b> Name of Medication	<b>6b.</b> Strength	<b>6c.</b> Total Quantity Required	<b>6d.</b> Total Quantity Required
<b>6e.</b> Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:		<b>6f.</b> Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 6l and/or Block 7	
<b>6g.</b> Prescribing Provider Name	<b>6h.</b> Prescribing Provider Phone Number	<b>6i.</b> Prescribing Provider Phone Number (alternate)	
<b>6j.</b> Reason for medication <i>(Describe in detail if necessary)</i>			
<b>6k.</b> Relevant side effects to be observed if any: <i>(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)</i>			
<b>6l.</b> List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
<b>6m.</b> Expected effects if medication is not taken as directed			
<b>7. REMARKS</b> (please include comments as required by Blocks 4, 5 and/or 6. Also provide any other medical history that you or your physician deems important)			
<b>8. STATEMENT OF UNDERSTANDING AND CONSENT</b>			Parent/Guardian Initial Below
<b>8a.</b> During the NSCC/NLCC training evolution, NSCC medical personnel on duty and/or assigned NSCC staff members have my permission to administer the medication listed in Block 4, Block 5 and/or Block 6. I understand that all medications provided to the NSCC training contingent staff, must be in the original medication bottle containing all of the information required by Block 4, 5, and/or 6.			
<b>8b.</b> I give consent to the NSCC staff to contact the medical provider as needed for clarification with regard to medications listed and the conditions for which the medication is prescribed. The medical provider has been notified that the NSCC is authorized to obtain medical/prescription information if necessary.			
<b>8c.</b> I understand that all medications will be collected at the beginning of training and 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 medication whether it is over the counter or prescription. I understand I must provide the required amount of medication needed for the entire duration of the training evolution.			
<b>8d.</b> I understand that the Commanding Officer of the Training Contingent (COTC), and/or National Headquarters (NHQ) retains the authority to not accept and/or terminate Cadet's training at any time due to medical/other reasons. If terminated, parent agrees to immediately pick up their son/daughter upon notification by the COTC and/or training staff.			
<b>9. AUTHORIZATION AND RELEASE</b>			
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 and 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>9a.</b> Name of Parent/Guardian (Type or Print)	<b>9b.</b> Signature	<b>9c.</b> Date (DD MMM YY)	
<b>10. ENDORSEMENTS</b>			
I have reviewed the medical record of this cadet and certify that the medications listed on this form are true and correct as prescribed and that this cadet is physically able to attend the listed training evolution.			
<b>10a.</b> Name of Medical Provider (Type or Print)	<b>10b.</b> Signature	<b>10c.</b> Date (DD MMM YY)	
I certify that I have reviewed the above information and the Cadet listed on this form is physically able to attend the listed training evolution.			
<b>10d.</b> Name of Commanding Officer (Type or Print) LTJG Samuel Elliott	<b>10e.</b> Signature	<b>10f.</b> Date (DD MMM YY)	



<b>U.S. NAVAL SEA CADET CORPS</b> <b>U.S. NAVY LEAGUE CADET CORPS</b>	<b>CADET APPLICATION</b> <b>REQUEST FOR ACCOMMODATION</b>	<i>FOR OFFICIAL USE ONLY</i>
<b>INSTRUCTIONS</b>		
Complete this form <u>ONLY</u> when an accommodation is requested for a prospective cadet under the Americans with Disabilities Act		
<b>1. UNIT INFORMATION</b>		
<b>1a. Unit Name</b> <b>William E. Taylor Division</b>	<b>1b. Region</b> <b>043TAY</b>	<b>1c. Date of Request (DD MMM YY)</b>
<b>1d. Full Name and Rank of Commanding Officer</b> LTJG Samuel Elliott	<b>1e. Commanding Officer's Phone Number</b> <b>302-275-7710</b>	<b>1f. Commanding Officer Email Address</b> <b>selliot@seacadets.org</b>
<b>2. CADET INFORMATION</b>		
<b>2a. Last Name</b>	<b>2b. First Name</b>	<b>2c. MI</b>
<b>2d. Age</b>	<b>2e. Parent/Guardian Names(s)</b>	<b>2f. Parent/Guardian(s) Phone Number</b>
<b>2g. Parent/Guardian(s) Email Address</b>		
<b>3. ASSESSMENT (Completed by Parent/Guardian with assistance of the Unit Commanding Officer)</b>		
My Son/Daughter's disability is ( <i>optional</i> ):		
<b>4. ACCOMMODATION</b>		
I am requesting the following accommodation for my son/daughter:		
<b>5. DETERMINATION</b>		
If Unit Commanding Officer determines accommodation is considered not reasonable, or cannot be made, Unit Commanding Officer must so state, with firm reasons and further forward to the Regional Director for review/comment and NHQ Representative for final determination. Reason for not approving is:		
<b>6. ACCOMMODATION PLAN</b>		
If Unit Commanding Officer agrees, the plan of accommodation based on individual assessment to allow enrollment and participation, agreed to by all parties, is (be specific as to can do's, and can't do's, limitations, escorting requirements, Recruit Trainings and advanced training, and alternate activities/events, etc. <i>Note: Plan can be modified/adjusted/refined at any time.</i> ):		

<b>REQUEST FOR ACCOMMODATION</b>		
<b>7. ENDORSEMENTS</b>		
<b>7a.</b> Full Name of Parent/Guardian (Print or Type)	<b>7b.</b> Signature	<b>7c.</b> Date (DD MMM YY)
<b>7d.</b> Full Name and Rank of Commanding Officer (Print or Type) LTJG Samuel Elliott	<b>7e.</b> Signature	<b>7f.</b> Date (DD MMM YY)
<b>FORWARD TO REGIONAL DIRECTOR FOR RECOMMENDATION</b>		
<b>8. REGIONAL DIRECTOR'S RECOMMENDATION:</b> <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove		
Reason for Disapproval or Recommended Modification:		
<b>8a.</b> Full Name and Rank of Regional Director (Print or Type)	<b>8b.</b> Signature	<b>8c.</b> Date (DD MMM YY)
<b>FORWARD TO NHQ REPRESENTATIVE FOR DECISION</b>		
<b>9. NHQ REPRESENTATIVE'S DECISION:</b> <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove		
Reason for Disapproval or Recommended Modification (if modification is recommended, request is returned to the Unit Commanding Officer for further negotiation with parent/guardian regarding the plan for accommodation)		
<b>NHQ Representative retains originals; return copy of decision to Unit CO, copy to Regional Director and National Headquarters.</b>		
<b>9a.</b> Full Name and Rank of NHQ Representative (Print or Type)	<b>9b.</b> Signature	<b>9c.</b> Date (DD MMM YY)
Complaints regarding the <b><u>NHQ Representative's Decision</u></b> to limit participation of a cadet in NSCC activities and/or the denial of a reasonable accommodation should be forwarded to:		
Executive Director, Naval Sea Cadet Corps 2300 Wilson Blvd. Suite 200 Arlington, VA 22201-5435		
Complaints regarding any final <b><u>NSCC NHQ Decision</u></b> to limit the participation of a cadet in NSCC activities and/or the denial of a reasonable accommodation should be forwarded to:		
Assistant Secretary of the Navy (Manpower and Reserves) Department of the Navy 1000 Army Navy Drive Arlington, VA 20350-1000		

The adult leadership of the NSCC/NLCC is made up entirely of volunteers. Many are parents just like you. Now that your child is joining our program, we ask you to please look over this questionnaire to see if you might be able to help out in some way.

**Yes, I am willing to help out the unit with the following:**

- Volunteer as a uniformed adult leader (must meet weight requirements)
- Volunteer as a non-uniformed adult leader
- Join a Parent's Auxiliary Group
- Assist with unit recruiting
- Assist with unit fundraising
- Assist with unit morale activities (outings, picnics, dances, etc.)
- Assist with unit administrative functions (copying, typing, etc.)
- Assist with unit supply (issue uniforms, maintaining inventory)
- Become a member of the Navy League of the United States or Sponsoring Organization
- Make the NSCC a beneficiary of my Combined Federal Campaign contribution (CFC #10185)  
(Federal and Military Employees only)
- Commit to an annual donation to the unit of \$

If you can offer assistance with anything else that is not listed above please let us know:

Cadet Name (Last, First, MI Type or Print)

Parent/Guardian Name	Parent/Guardian Name
Relationship to Cadet	Relationship to Cadet
Home Phone	Home Phone
Work Phone	Work Phone
E-Mail Address	E-Mail Address
Times/Days you are available to assist	Times/Days you are available to assist