Florida Youth Law Cadet Academy Application

Florida American Legion Youth Law Cadet Academy, July 9-14, 2017

PHOTOGRAPH REQUIRED

The Florida Youth Law Cadet Academy is sponsored by the American Legion, Department of Florida in cooperation with the Florida Highway Patrol.

Please return this application with ALL fees, completed health forms, ID photo, and all permission forms to the American Legion, Department of Florida: PO Box 547859, Orlando, FL 32854
*Note: Only **completed** applications will be accepted*

Name:_____Nickname:_____

Address:_____
Street

_____
City State Zip Code

Home Phone:(_____) _____Cell Phone: (_____) _____

Email address:_____

Height:_____ Weight:_____ Date of Birth: _____ Age:_____

T-Shirt Size (based off of adult sizes):_____

Name of Parent(s) or Guardian(s):_____
Emergency Contact Information:
Home Phone:(_____) _____
Cell Phone:(_____) _____
Work Phone:(_____) _____
Email Address:_____

Name of High School:_____

Name of Hometown Newspaper:_____

List leadership activities in your school and community along with positions you have held in each activity, e.g., VP of student government, secretary of honor society, first chair in horn section in band, captain of soccer team, assistant editor of newspaper/yearbook, assistant patrol leader in Boy Scouts, VP of youth group at church, etc.:

_____

_____

_____

Last name: _____ DOB: _____ Allergies: _____ Emergency contact No.: _____

Cadet Academy Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male ☐ Female ☐

Address _____ Grade completed _____

City _____ State _____ Zip _____ Phone No. _____

Social Security No. (Optional; may be required by medical facilities for treatment) _____

Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. ***IF FAMILY HAS NO MEDICAL INSURANCE, Circle "NONE."***

In case of emergency, notify:

Name _____ Relationship _____

Address _____

Home phone _____ Business phone _____ Cell phone _____

Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____

Food, Plants, or Insect Bites _____

_____

Immunizations:

The following are recommended. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
☐	☐	Tetanus _____
☐	☐	Pertussis _____
☐	☐	Diptheria _____
☐	☐	Measles _____
☐	☐	Mumps _____
☐	☐	Rubella _____
☐	☐	Polio _____
☐	☐	Chicken pox _____
☐	☐	Hepatitis A _____
☐	☐	Hepatitis B _____
☐	☐	Influenza _____
☐	☐	Other (i.e., HIB) _____

☐ Exemption to immunizations claimed.

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____
_____
Distribution approved by:
_____/_____
Parent signature MD/DO. NP. or PA Signature
Temporary ☐ Permanent ☐

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____
_____
Distribution approved by:
_____/_____
Parent signature MD/DO. NP. or PA Signature
Temporary ☐ Permanent ☐

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____
Distribution approved by:
_____/_____
Parent signature MD/DO. NP. or PA Signature
Temporary Permanent

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____
Distribution approved by:
_____/_____
Parent signature MD/DO, NP, or PA Signature
Temporary ☐ Permanent ☐

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____
_____
Distribution approved by:
_____/_____
Parent signature MD/DO, NP, or PA Signature
Temporary ☐ Permanent ☐

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____
Distribution approved by:
_____/_____
Parent signature MD/DO, NP, or PA Signature
Temporary Permanent

NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Part B

PHYSICAL EXAMINATION

Heigh_____ Weight_____ Blood Pressure_____ Pulse_____

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs				**Other**	**Yes**	**No**	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			**Explain**
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			
Tuberculosis (TB) skin test				☐ Negative ☐ Positive			

Allergies (to what agent, type of reaction, treatment): _____

I certify that I have, today, reviewed the health history, examined this person, and approve this individual for participation in:

☐ Hiking and camping ☐ Competitive activities ☐ Backpacking ☐ Swimming/water activities ☐ Climbing/rappelling
☐ Sports ☐ Running ☐ Scuba diving ☐ Exercise ☐ Challenge ("ropes") course
☐ Hot-weather activity ☐ Wilderness/backcountry treks

Specify restrictions (if none, so state) _____

Certified and licensed health-care providers recognized to perform this exam include physicians (MD, DO), nurse practitioners, and physician's assistants.

To Health Care Provider: Restricted approval includes:
- → Uncontrolled heart disease, asthma, or hypertension.
- → Uncontrolled psychiatric disorders.
- → Poorly controlled diabetes.
- → Orthopedic injuries not cleared by a physician.
- → Newly diagnosed seizure events (within 6 months).
- → For scuba, use of medications to control diabetes, asthma, or seizures.

Provider printed name _____
Signature _____
Address _____
City, state, zip _____
Office phone _____
Date _____

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

DEPARTMENT OF FLORIDA YOUTH LAW CADET ACADEMY

PERMISSION TO PARTICPATE

If over eighteen, I agree to participate in all activities involved in The American Legion Youth Law Cadet Academy to include:

- Exercises
- Sports
- Defense Tactics
- Driving course, Firearms and any other activities of the program all of which will be supervised by certified personnel in that field

Cadet Signature:_____ Date:_____

Cadet Name Printed:_____

Post Sponsor Signature:_____ Date:_____

Post Sponsor Name Printed: _____

Or if under eighteen, I do hereby give permission for my son or daughter or legal ward to participate in all activities involved in The American Legion Youth Law Cadet Academy to include:

- Exercises
- Sports
- Defense Tactics
- Driving course, Firearms and any other activities of the program all of which will be supervised by certified personnel in that field

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name Printed:_____

Cadet Name:_____

Post Sponsor Signature:_____ Date:_____

Post Sponsor Name Printed: _____

DEPARTMENT OF FLORIDA/ FHP LAW CADET ACADEMY

RELEASE AND HOLD HARMLESS AGREEMENT

In consideration for being allowed to participate voluntarily in The American Legion Youth Law Cadet Academy, I hereby release the Florida Highway Patrol and the American Legion Department of Florida from any and all liabilities or claims arising from my own participation. I agree that I will never prosecute or in any way aid in prosecuting any person or property that may occur from any cause whatsoever as a result of taking part in this activity.

Signature of Cadet (age 18): _____
Date:_____

FOR MINOR CHILD:

I, _____, parent/legal guardian of the above said minor child, consent to his or her taking part in this moral support activity. I will abide by the above.

Signature of Parent/Guardian:_____
Date:_____