

Cadet Academy Health and Medical Record

Part A

GENERAL INFORMATION:

F/ L Name: _____ Date of Birth: _____ Age: _____

Address: _____ Grade Completed: _____

City: _____ State: Florida Zip Code: _____ Phone No.: _____

Health/ Accident Insurance Company: _____ Policy No.: _____

Attach a Photocopy of BOTH sides of Insurance Card. If Family has NO Medical Insurance, write "NONE."

In case of emergency, notify:

F/ L Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Alternate Contact Name: _____ Phone No.: _____

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	
		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	
		Severe Injury	
		Other	

ALLERGIES OR REACTION TO:

Last Name: _____
DOB: _____ Page 2 of 3

Medications: _____

Food: _____

Other: _____

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	Immunization	Date
		Tetanus	
		Pertussis	
		Diphtheria	
		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 attach list to application.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication: _____ Strength: _____ Frequency: _____ Approx. date started: _____ Reason for medication: _____ Distribution approved by: _____ Parent Initials MD/DO, NP, or PA Initials Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication: _____ Strength: _____ Frequency: _____ Approx. date started: _____ Reason for medication: _____ Distribution approved by: _____ Parent Initials MD/DO, NP, or PA Initials Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication: _____ Strength: _____ Frequency: _____ Approx. date started: _____ Reason for medication: _____ Distribution approved by: _____ Parent Initials MD/DO, NP, or PA Initials Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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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.

Last Name: _____

DOB: _____ Page 3 of 3

Part B

PHYSICAL EXAMINATION:

Height: _____ 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	Negative <input type="checkbox"/>		Positive <input type="checkbox"/>				

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 & 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: _____

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:_____