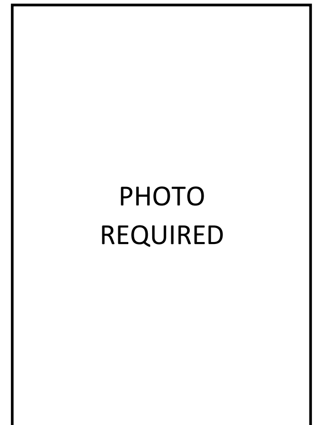
<u>Florida Youth Law Cadet Academy Application</u>

Florida American Legion Youth Law Cadet Academy, July 10-15, 2022



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 **Dept. Youth Law Cadet Chairman,**
Bob Brewster 2872 Circle Ridge Drive Orange Park, FL 32065
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.:

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Youth Law 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	

Last Name: ______________________________

DOB: ______________________

ALLERGIES OR REACTION TO:

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	
		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 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 ☐ Permanent ☐	Medication: ____________________ Strength: _____ Frequency: ________ Approx. date started: _____________ Reason for medication: ___________ ______________________________ Distribution approved by: _____________/ ________________ Parent Initials MD/DO, NP, or PA Initials Temporary ☐ Permanent ☐	Medication: ____________________ Strength: _____ Frequency: ________ Approx. date started: _____________ Reason for medication: ___________ ______________________________ Distribution approved by: _____________/ ________________ Parent Initials MD/DO, NP, or PA Initials Temporary ☐ Permanent ☐
Medication: ____________________ Strength: _____ Frequency: ________ Approx. date started: _____________ Reason for medication: ___________ ______________________________ Distribution approved by: _____________/ ________________ Parent Initials MD/DO, NP, or PA Initials Temporary ☐ Permanent ☐	Medication: ____________________ Strength: _____ Frequency: ________ Approx. date started: _____________ Reason for medication: ___________ ______________________________ Distribution approved by: _____________/ ________________ Parent Initials MD/DO, NP, or PA Initials Temporary ☐ Permanent ☐	Medication: ____________________ Strength: _____ Frequency: ________ Approx. date started: _____________ Reason for medication: ___________ ______________________________ Distribution approved by: _____________/ ________________ Parent Initials MD/DO, NP, or PA Initials 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.

Last Name: ________________________________

DOB: ________________________

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 ☐		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 & 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): ____

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

To Heath 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 YOUTH 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:_____________