

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION MEMBER INFORMATION	<i>FOR OFFICIAL USE ONLY</i>	
INSTRUCTIONS			
<ol style="list-style-type: none"> 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. 			
1. APPLICANT INFORMATION			
1a. Last Name	1b. First Name	1c. Middle Name	1d. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
1e. Home Address	1f. City	1g. State	1h. Zip Code + 4
1i. Social Security Number	1j. Date of Birth (DD MMM YY)	1k. Primary Phone	1l. E-Mail Address
1m. Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes grade:</i>	1n. School Name & City		1o. GPA
1p. Has the applicant ever been charged OR 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>			
1q. Citizenship <input type="checkbox"/> U.S. Citizen Legal Resident - Registration Number:		1r. Referred/Recruited by (Cadet Name, if applicable)	
2. APPLICANT AGREEMENT AND CONFIRMATION I agree to be governed by the regulations for administration of the NSCC/NLCC; and to obey all lawful orders, to attend drills regularly, and to take proper care of any uniforms or equipment entrusted to me. I also commit to being drug, alcohol, and gang free while I am a member of the NSCC/NLCC.			
2a. Applicant Signature			2b. Date (DD MMM YY)
3. PRIMARY PARENT/LEGAL GUARDIAN INFORMATION <i>(will be listed as next of kin and first contact in case of an emergency)</i>			
3a. Name		3b. Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	
3c. Address	3d. City	3e. State	3f. Zip Code + 4
3g. Primary Phone	3h. Alternate Phone	3i. E-Mail Address	
4. SECONDARY PARENT/LEGAL GUARDIAN CONTACT INFORMATION			
4a. Name		4b. Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	
4c. Address	4d. City	4e. State	4f. Zip Code + 4
4g. Primary Phone	4h. Alternate Phone	4i. E-Mail Address	
5. EMERGENCY CONTACT INFORMATION <i>(will be contacted in case primary or secondary contacts are unreachable in case of an emergency)</i>			
5a. Name		5b. Relationship <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Family Friend	
5c. Address	5d. City	5e. State	5f. Zip Code + 4
5g. Primary Phone	5h. Alternate Phone	5i. E-Mail Address	
6. DEMOGRAPHICS			
6a. 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			
6b. 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			

MEMBER INFORMATION

8. PARENT/LEGAL GUARDIAN AGREEMENT & CONFIRMATION

I hereby consent to my child/ward enrolling in the Naval Sea Cadet Corps (NSCC)/Navy League Cadet Corps (NLCC). I understand that the NSCC/NLCC is organized along military lines and that NSCC/NLCC regulations govern my child's/ward's membership and that violation of regulations may result in my child's/ward's discharge from the NSCC/NLCC. 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 or if not, 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 Naval Sea Cadet Corps 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 Naval Sea Cadet officer or other authorized agent. I have been briefed on the NSCC 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 NSCC 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 to be bound by all NSCC regulations, policies, and amendments thereof that govern my child's/ward's membership and conduct; I further waive any right to challenge in any way any determination made by the NSCC/NLCC regarding my child's/ward's continuance of membership in the NSCC/NLCC 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 U.S. Naval Sea Cadet Corps (NSCC)/U.S. Navy League Cadet Corps (NLCC), in consideration of his/her acceptance and continuance of membership in the NSCC/NLCC, 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 NSCC/NLCC activities take place; (3) the Navy League of the United States; (4) any organization or association, public or private, that sponsors NSCC/NLCC activities; (5) the NSCC/NLCC; (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 Nationwide Life Insurance Company Specified Hazard Group Insurance Certificate for the United States Naval Sea Cadet Corps (NSCC) (Policy 502-95-21736).

I consent to the examination of my son/daughter/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 NSCC/NLCC. 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 NSCC/NLCC 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 son/daughter/ward to be transported as a passenger in military aircraft, vessels and vehicles.

I consent to my son/daughter/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 NSCC 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 son's/daughter's/ward's membership in the NSCC/NLCC. I also give my permission for facsimiles of this release to be made, and when presented by an authorized official of the NSCC/NLCC, DOD, USCG, NOAA shall be considered as valid as the original signed by me.

9a. Cadet Full Name

9b. Social Security 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)

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
Cadet Application and Agreement		ID Card Returned		
Parental Support Agreement		Uniforms Returned		
Accommodation Agreement		Deposit Refunded		
Report of Medical History		NSCADM 009 to NHQ		
Report of Medical Examination		Reason for Disenrollment		
Fees Collected				
Enrollment (NSCADM 007) to NHQ				

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION REPORT OF MEDICAL HISTORY	FOR OFFICIAL USE ONLY
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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					
1a. Unit Name					1b. Region
2. PERSONAL INFORMATION					
2a. Last Name		2b. First Name		2c. MI	2d. Social Security Number
2e. Age	2f. Date of Birth (DD MMM YY)	2g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	2h. Parent/Guardian Name		
2i. Home Address		2j. City		2k. State	2l. Zip Code + 4
2m. Primary Phone		2n. Alternate Phone		2o. Date of Last Physical Examination (DD MMM YY)	
3. MEDICAL PROVIDER/INSURANCE INFORMATION					
3a. Medical Insurance Provider Name				3b. Medical Insurance Policy Number	
3c. Medical Insurance Provider Address				3d. Medical Insurance Provider Phone	
3e. Medical Provider Name				3f. Medical Provider Phone Number	
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	
		<input type="checkbox"/>	<input type="checkbox"/>		
4a. Tuberculosis or live with someone with tuberculosis				4n. Head injury or concussion	
		<input type="checkbox"/>	<input type="checkbox"/>		
4b. Chronic or recurrent abdominal or stomach pain				4o. Seizures, convulsions, epilepsy, or fits	
		<input type="checkbox"/>	<input type="checkbox"/>		
4c. Asthma or breathing problems related to exercise, pollen, etc.				4p. Car, train, sea, and/or air sickness	
		<input type="checkbox"/>	<input type="checkbox"/>		
4d. Been prescribed or use an inhaler				4q. A period of unconsciousness	
		<input type="checkbox"/>	<input type="checkbox"/>		
4e. Loss of vision in either eye				4r. Heart trouble or murmur	
		<input type="checkbox"/>	<input type="checkbox"/>		
4f. Loss of hearing or wear a hearing aid				4s. Received counseling for emotional or behavior disorder	
		<input type="checkbox"/>	<input type="checkbox"/>		
4g. Impaired use of arms, legs, hands, feet				4t. Eating disorder (bulimia, anorexia)	
		<input type="checkbox"/>	<input type="checkbox"/>		
4h. Knee problems				4u. Sleepwalking	
		<input type="checkbox"/>	<input type="checkbox"/>		
4i. Broken bones(s) (cracked or fractured)				4v. Bedwetting	
		<input type="checkbox"/>	<input type="checkbox"/>		
4j. Diabetes				4w. Been hospitalized (if yes, why, when, where)	
		<input type="checkbox"/>	<input type="checkbox"/>		
4k. Anemia (including sickle cell)				4x. Any illness or injury not mentioned above (if yes, explain)	
		<input type="checkbox"/>	<input type="checkbox"/>		
4l. Dizziness or fainting spells (including after exercise)				4y. Advised to avoid certain physical activities (if yes, explain)	
		<input type="checkbox"/>	<input type="checkbox"/>		
4m. Frequent or severe headaches				4z. FEMALES ONLY: At what age did you begin menstrual cycle:	
		<input type="checkbox"/>	<input type="checkbox"/>		

REPORT OF MEDICAL HISTORY

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

5a. Date of last tetanus or booster

5b. Date of Menactra Vaccine for Meningitis

5c. Date of negative PPD or Medical Provider Clearance for TB

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
6a. Bee or wasp sting	<input type="checkbox"/>	<input type="checkbox"/>	6e. Latex	<input type="checkbox"/>	<input type="checkbox"/>
6b. Hay Fever or seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	6f. Any drug, e-mycin antibiotic, or sulfa allergies, list in Block 9	<input type="checkbox"/>	<input type="checkbox"/>
6c. Insect bites	<input type="checkbox"/>	<input type="checkbox"/>	6g. Other allergies, list in Block 9	<input type="checkbox"/>	<input type="checkbox"/>
6d. Iodine/seafood	<input type="checkbox"/>	<input type="checkbox"/>	6h. 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.

10a. Parent/Guardian Name (Type or Print)

10b. Signature

10c. Date (DD MMM YY)

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

1a. Unit Name	1b. Region
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2. PERSONNEL INFORMATION

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

3. CLINICAL EVALUATION

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

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

5a. Height inches	5b. Weight lbs.	5c. Obese <input type="checkbox"/> Yes <input type="checkbox"/> No	5d. Pulse	5e. Blood Pressure (1) Systolic: _____ (2) Diastolic: _____				
5f. Audiogram (if available)				5g. Wears Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No				
HZ	500	1000	2000	3000	4000	6000	5h. Wears Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No	5i. Uncorrected Vision (1) Left: 20/ _____ (2) Right: 20/ _____
Right							5j. Color Vision	
Left								

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. <input type="checkbox"/> CLEARED WITHOUT RESTRICTIONS				
8b. <input type="checkbox"/> Cleared AFTER further evaluation or treatment for:				
8c. <input type="checkbox"/> Cleared for LIMITED participation				
<input type="checkbox"/> Not cleared for (specify activities): <input type="checkbox"/> Cleared only for (specify activities): Reasons:				
8d. <input type="checkbox"/> NOT CLEARED FOR PARTICIPATION				
Reasons:				
8e. <input type="checkbox"/> OTHER RECOMMENDATIONS				
<input type="checkbox"/> Recommend close monitoring during conditioning because of weight/fitness/other.				
<input type="checkbox"/> Recommend restrictions or monitoring of weight loss/gain or fitness concerns.				
<input type="checkbox"/> Recommend participation under following condition(s):				
<input type="checkbox"/> Other:				
9. MEDICAL PROVIDER				
9a. Name of Medical Provider (Type or Print) or Medical Provider Stamp		9b. Signature (MD, DO, NP, PA)		9c. Date (DD MMM YY)
9b. Medical Provider Address		9c. City	9c. State	10c. Zip Code +4
				9c. 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

1a. Last Name	1b. First Name	1c. MI	1d. Social Security Number
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2. TRAINING INFORMATION

2a. Training Code	2b. Training Start Date	2c. Training End Date	2d. Training Days	2d. Training Location
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3. PACKAGING AND LABELING REQUIREMENTS

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

4a. Name of Medication	4b. Strength	4c. Total Quantity Required	4d. Total Quantity Sent
4e. Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	4f. 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 4l and/or Block 7		
4g. Prescribing Provider Name	4h. Prescribing Provider Phone Number	4i. Prescribing Provider Phone Number (alternate)	
4j. Reason for medication <i>(Describe in detail if necessary)</i>			
4k. 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>			
4l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
4m. 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)*

5a. Name of Medication	5b. Strength	5c. Total Quantity Required	5d. Total Quantity Sent
5e. Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	5f. 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 5l and/or Block 7		
5g. Prescribing Provider Name	5h. Prescribing Provider Phone Number	5i. Prescribing Provider Phone Number (alternate)	
5j. Reason for medication <i>(Describe in detail if necessary)</i>			
5k. 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>			
5l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activates or location.			
5m. Expected effects if medication is not taken as directed.			

MEDICAL HISTORY SUPPLEMENTAL

6. PRESCRIPTION OR NON-PRESCRIPTION MEDICATION <i>(Use additional documents if more than three medications are provided)</i>			
6a. Name of Medication	6b. Strength	6c. Total Quantity Required	6d. Total Quantity Required
6e. Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	6f. 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		
6g. Prescribing Provider Name	6h. Prescribing Provider Phone Number	6i. Prescribing Provider Phone Number (alternate)	
6j. Reason for medication <i>(Describe in detail if necessary)</i>			
6k. 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>			
6l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
6m. Expected effects if medication is not taken as directed			
7. REMARKS (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)			
8. STATEMENT OF UNDERSTANDING AND CONSENT			Parent/Guardian Initial Below
8a. 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.			
8b. 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.			
8c. 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.			
8d. 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.			
9. 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 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.			
9a. Name of Parent/Guardian (Type or Print)	9b. Signature	9c. Date (DD MMM YY)	
10. ENDORSEMENTS			
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.			
10a. Name of Medical Provider (Type or Print)	10b. Signature	10c. 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.			
10d. Name of Commanding Officer (Type or Print)	10e. Signature	10f. Date (DD MMM YY)	

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION REQUEST FOR ACCOMMODATION	<i>FOR OFFICIAL USE ONLY</i>
INSTRUCTIONS		
Complete this form <u>ONLY</u> when an accommodation is requested for a prospective cadet under the Americans with Disabilities Act		
1. UNIT INFORMATION		
1a. Unit Name	1b. Region	1c. Date of Request (DD MMM YY)
1d. Full Name and Rank of Commanding Officer	1e. Commanding Officer's Phone Number	1f. Commanding Officer Email Address
2. CADET INFORMATION		
2a. Last Name	2b. First Name	2c. MI
2d. Age	2e. Parent/Guardian Names(s)	
2f. Parent/Guardian(s) Phone Number		2g. Parent/Guardian(s) Email Address
3. ASSESSMENT (Completed by Parent/Guardian with assistance of the Unit Commanding Officer)		
My Son/Daughter's disability is <i>(optional)</i> :		
4. ACCOMMODATION		
I am requesting the following accommodation for my son/daughter:		
5. DETERMINATION		
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:		
6. ACCOMMODATION PLAN		
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>):		

REQUEST FOR ACCOMMODATION

7. ENDORSEMENTS

7a. Full Name of Parent/Guardian (Print or Type)	7b. Signature	7c. Date (DD MMM YY)
7d. Full Name and Rank of Commanding Officer (Print or Type)	7e. Signature	7f. Date (DD MMM YY)

FORWARD TO REGIONAL DIRECTOR FOR RECOMMENDATION

8. REGIONAL DIRECTOR'S RECOMMENDATION: Approve Disapprove

Reason for Disapproval or Recommended Modification:

8a. Full Name and Rank of Regional Director (Print or Type)	8b. Signature	8c. Date (DD MMM YY)
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FORWARD TO NHQ REPRESENTATIVE FOR DECISION

9. NHQ REPRESENTATIVE'S DECISION: Approve 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)

NHQ Representative retains originals; return copy of decision to Unit CO, copy to Regional Director and National Headquarters.

9a. Full Name and Rank of NHQ Representative (Print or Type)	9b. Signature	9c. Date (DD MMM YY)
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Complaints regarding the **NHQ Representative's Decision** 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 **NSCC NHQ Decision** 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