Instructions for:

Pages 1 & 2 Cadet Data

- Complete all the required boxes, Print or save the document
- Provide a passport type photo of your cadet that includes shoulders and face against a solid white background.

Pages 3 & 4 Medical History

- Complete all the required boxes, Print, or save the document
- This portion of the medical forms does not need a doctor's examination
- Provide a copy of the front and back of your current medical insurance card
- Provide a copy of the cadet's vaccinations card (COVID-19 Vaccine is not a requirement)

Pages 7 &8 Medical Supplemental

- Complete all the required boxes, Print or save the document
- If no medications are taken write NONE

Pages 9 & 10 Medical Accommodation Form

- Complete all the required boxes, Print or save the document
- If your cadet has any medical disability and requires special care. Please fill this out and be as descriptive as possible. Some requests cannot be accommodated at our unit. If this is the case we will do what we can to find a unit that will work best for you.

Page 11 Parental Agreement

- We are always looking for parent volunteers to assist in a variety of assignments.
- There are uniformed and non-uniformed positions available
- We always encourage parents to be part of their cadets journey

When the above forms are completed scan them and email them to admin@bmbseacadets.org

Pages 5 & 6 Medical Exam

- Print the form and have your cadets Doctor Complete all the required boxes
- When the form is completed scan the form and email it to admin@bmbseacadets.org

Pages 1 & 2 Cadet Data

Complete all the required boxes, Print or save the document

Provide a passport type photo of your cadet that includes shoulders and face against a solid white background.

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	**CADET APPLICATION** **MEMBER INFORMATION**	*FOR OFFICIAL USE ONLY*

INSTRUCTIONS

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 ☐ Male ☐ Female
1e. Home Address	**1f.** City	**1g.** State	**1h.** Zip Code + 4
1j. Date of Birth (DD MMM YY)	**1k.** Primary Phone	**1l.** E-Mail Address	
1m. Full-time Student? ☐ Yes ☐ No *If yes grade:*	**1n.** School Name & City		**1o.** GPA

1p. Has the applicant ever been charged **OR** convicted of a criminal offense? *(use an additional sheet if necessary)*

☐ Yes ☐ No *If yes please explain:*

1q. Citizenship ☐ U.S. Citizen ☐ Legal Resident - Registration Number:	**1r.** Referred/Recruited by (Cadet Name, if applicable)

2. APPLICANT PROMISE

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.

2a. Applicant Signature	**2b.** Date (DD MMM YY)

3. PRIMARY PARENT/LEGAL GUARDIAN INFORMATION *(will be listed as next of kin and first contact in case of an emergency)*

3a. Name	**3b.** Relationship ☐ Mother ☐ Father ☐ Guardian ☐ 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 ☐ Mother ☐ Father ☐ Guardian ☐ 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 (*will be contacted in case primary or secondary contacts are unreachable in case of an emergency*)

5a. Name	**5b.** Relationship ☐ Grandparent ☐ Other Relative ☐ 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

☐ White (Non-Hispanic) ☐ Black (Non-Hispanic) ☐ Hispanic ☐ Asian ☐ Native American/Alaskan Eskimo ☐ Pacific Islander ☐ Other ☐ Decline to State

6b. Community Profile

☐ Inner City ☐ Urban ☐ Suburban ☐ Rural ☐ Other ☐ 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)	**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**		
Report of Medical History		**Uniforms Returned**		
Report of Medical Examination		**Reason for Disenrollment**		
Fees Collected				

Pages 3 & 4 Medical History

Complete all the required boxes, Print, or save the document

This portion of the medical forms does not need a doctor's examination

Provide a copy of the front and back of your current medical insurance card

Provide a copy of the cadet's vaccinations card (COVID-19 Vaccine is not a requirement)

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	**CADET APPLICATION** **REPORT OF MEDICAL HISTORY**	FOR OFFICIAL USE ONLY

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.** USNSCC ID Number

2e. Age	**2f.** Date of Birth (DD MMM YY)	**2g.** Sex ☐ Male ☐ 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**		**YES**	**NO**
4a. Tuberculosis or live with someone with tuberculosis	☐	☐	**4n.** Head injury or concussion	☐	☐
4b. Chronic or recurrent abdominal or stomach pain	☐	☐	**4o.** Seizures, convulsions, epilepsy, or fits	☐	☐
4c. Asthma or breathing problems related to exercise, pollen, etc.	☐	☐	**4p.** Car, train, sea, and/or air sickness	☐	☐
4d. Been prescribed or use an inhaler	☐	☐	**4q.** A period of unconsciousness	☐	☐
4e. Loss of vision in either eye	☐	☐	**4r.** Heart trouble or murmur	☐	☐
4f. Loss of hearing or wear a hearing aid	☐	☐	**4s.** Received counseling for emotional or behavior disorder	☐	☐
4g. Impaired use of arms, legs, hands, feet	☐	☐	**4t.** Eating disorder (bulimia, anorexia)	☐	☐
4h. Knee problems	☐	☐	**4u.** Sleepwalking	☐	☐
4i. Broken bones(s) (cracked or fractured)	☐	☐	**4v.** Bedwetting	☐	☐
4j. Diabetes	☐	☐	**4w.** Been hospitalized *(if yes, why, when, where)*	☐	☐
4k. Anemia (including sickle cell)	☐	☐	**4x.** Any illness or injury not mentioned above *(if yes, explain)*	☐	☐
4l. Dizziness or fainting spells (including after exercise)	☐	☐	**4y.** Advised to avoid certain physical activities *(if yes, explain)*	☐	☐
4m. Frequent or severe headaches	☐	☐	**4z. FEMALES ONLY:** At what age did you begin menstrual cycle:		

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	☐	☐	**6e.** Latex	☐	☐
6b. Hay Fever or seasonal allergies	☐	☐	**6f.** Any drug, e-mycin antibiotic, or sulfa allergies, list in Block 9	☐	☐
6c. Insect bites	☐	☐	**6g.** Other allergies, list in Block 9	☐	☐
6d. Iodine/seafood	☐	☐	**6h.** Food allergies, list in Block 9	☐	☐

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)

Pages 7 &8 Medical Supplemental

Complete all the required boxes, Print or save the document

If no medications are taken write NONE

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	**CADET APPLICATION** **MEDICAL HISTORY SUPPLEMENTAL**	*FOR OFFICIAL USE ONLY*

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.** USNSCC ID Number

2. TRAINING INFORMATION

2a. Training Code	**2b.** Training Start Date	**2c.** Training End Date	**2d.** Training Days	**2d.** Training Location
			0	

3. PACKAGING AND LABELING REQUIREMENTS

3a. Prescription Medication
- 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)
- 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.

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)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:

4f. Frequency and Dosage (check one)
☐ As needed, as labeled ☐ On schedule, as labeled ☐ 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 *(Describe in detail if necessary)*

4k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

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)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:

5f. Frequency and Dosage (check one)
☐ As needed, as labeled ☐ On schedule, as labeled ☐ 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 *(Describe in detail if necessary)*

5k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

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 *(Use additional documents if more than three medications are provided)*

6a. Name of Medication	**6b.** Strength	**6c.** Total Quantity Required	**6d.** Total Quantity Required

6e. Storage (Use Block 7, if necessary)	**6f.** Frequency and Dosage (check one)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:	☐ As needed, as labeled ☐ On schedule, as labeled ☐ 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 *(Describe in detail if necessary)*

6k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

6l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activates 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)

Pages 9 & 10 Medical Accommodation Form

Complete all the required boxes, Print or save the document

If your cadet has any medical disability and requires special care. Please fill this out and be as descriptive as possible. Some requests cannot be accommodated at our unit. If this is the case we will do what we can to find a unit that will work best for you.

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	**CADET APPLICATION** **REQUEST FOR ACCOMMODATION**	*FOR OFFICIAL USE ONLY*

INSTRUCTIONS

Complete this form ONLY 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 (*optional*):

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. *Note: Plan can be modified/adjusted/refined at any time*.):

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)

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)

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

Page 11 Parental Agreement

We are always looking for parent volunteers to assist in a variety of assignments.

There are uniformed and non-uniformed positions available

We always encourage parents to be part of their cadets journey

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	**CADET APPLICATION** **PARENTAL SUPPORT AGREEMENT**	*FOR OFFICIAL USE ONLY*

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

When the above forms are completed scan them and email them to

admin@bmbseacadets.org

Pages 5 & 6 Medical Exam

Print the form and have your cadets Doctor Complete all the required boxes

When the form is completed scan the form and email it to admin@bmbseacadets.org

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION REPORT OF MEDICAL EXAM	*FOR OFFICIAL USE ONLY*

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

2. PERSONNEL INFORMATION

2a. Last Name	**2b.** First Name	**2c.** MI	**2d.** USNSCC ID Number

2e. Age	**2f.** Date of Birth (DD MMM YY)	**2g.** Sex ☐ Male ☐ 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 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	☐	☐	
3b. Nose	☐	☐	
3c. Sinuses	☐	☐	
3d. Ears – General *(Internal and External Canals)*	☐	☐	
3e. Drum *(Perforation)*	☐	☐	
3f. Eyes- General	☐	☐	
3g. Ophthalmoscopic	☐	☐	
3h. Pupils *(Equality and Reaction)*	☐	☐	
3i. Heart *(Thrust, Size, Rhythm, and Sounds)*	☐	☐	
3j. Lungs and Chest	☐	☐	
3k. Abdomen and Viscera *(Include Hernia)*	☐	☐	
3l. External Genitalia *(Genitourinary)*	☐	☐	
3m. Upper Extremities	☐	☐	
3n. Lower Extremities	☐	☐	
3o. Feet	☐	☐	
3p. Spine and other Musculoskeletal	☐	☐	

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		**4b.** Blood	
(1) Albumin:	(2) Sugar:	(1) Hemoglobin:	(2) Hematocrit:

5. MEASUREMENTS AND OTHER FINDINGS

5a. Height inches	**5b.** Weight lbs.	**5c.** Obese ☐ Yes ☐ No	**5d.** Pulse	**5e.** Blood Pressure (1) Systolic:	 (2) Diastolic:

5f. Audiogram (if available)

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

5g. Wears Glasses ☐ Yes ☐ No	**5h.** Wears Contacts ☐ Yes ☐ No	**5i.** Uncorrected Vision (1) Left: 20/	 (2) Right: 20/

5j. Color Vision

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	☐ Yes ☐ No	
6b. Asthma	☐ Yes ☐ No	
6c. Symptomatic/recurring orthopedic injury	☐ Yes ☐ No	
6d. Diabetes, Type I	☐ Yes ☐ No	
6e. Diabetes, Type II	☐ Yes ☐ No	
6f. Hypersensitivity to Food	☐ Yes ☐ No	
6g. Insect bites/stings sensitivity	☐ Yes ☐ No	
6h. Head injuries resulting in residual impairment	☐ Yes ☐ No	
6i. Neurological Impairment	☐ Yes ☐ No	
6j. History of recurring loss of consciousness	☐ Yes ☐ No	
6k. History of debilitating motion sickness	☐ Yes ☐ No	
6l. Sleepwalking	☐ Yes ☐ No	
6m. Bedwetting	☐ Yes ☐ 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

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