# JCLC Summer Camp Example Packet

Please fill out all highlighted areas.

A

## JCLC 2019 Camp All American
## Cadet Medical History

1. The purpose of this form is to obtain basic in-processing information and to determine if your cadet is medically qualified to attend this year's JROTC Cadet Leadership Challenge (JCLC).
2. The form can be filled out by the cadet's parent or legal guardian.
3. Please provide the following cadet information:

High School JUPITER

Name - Last, First, MI LAST FIRST MIDDLE INITIAL

Home Address YOUR ADDRESS

Student Number 123456789 Grade WHAT GRADE LET Level YOUR CURRENT

4. Current Medications (Prescription and Over-the-Counter) / Frequency / Dosage

PRESCRIPTION ZOMI / 1X DAILY / 50MG

_____ / _____ / _____

_____ / _____ / _____

5. Allergies (Including insect bites/stings, food, medicines, other)

NONE OR LIST ANY

6. Medical History. Please answer yes or no if your cadet has or had ever had the following medical condition

| Medical Condition | Yes | No | Comments |
|---|---|---|---|
| Heart Disease / Murmur | | | |
| Asthma /Use of an Inhaler | | | |
| Anxiety | | | |
| Severe Allergies | | | |
| Rheumatic Fever | | | |
| Ear Infection | | | |
| Headaches | | | |
| Diabetes | | | |
| Prior Heat Injuries | | | |
| Epilepsy / Seizures | | | |
| Fainting / Passing Out | | | |

**EMERGENGY CONTACT NAME / NUMBER**

Name /# A CONTACT / Name /# 931-121-4567

Signature of Parent or Legal Guardian

Date 5/13/19

B

## CONTRACT OF RELEASE AND WAIVER OF LIABILITY

I, _____, ("Participant/Releasor"), acknowledge and agree that I have voluntarily applied to participate in ROTC/JROTC military-style training activities ("Training"), which may include any of the following (examples include, but are not limited to): rock climbing, rappelling, drill and ceremonies (marching and parades), field training, military maneuvers, water events (such as swimming, boating, rafting or any event involving water that is not specifically mentioned elsewhere), sports or athletic events (which may involve rigorous exercise), rope climbing (includes any event involving a rope that is not specifically mentioned elsewhere), and similar such activities:

**I AM AWARE AND ACKNOWLEDGE THAT THE ACTIVITIES IN WHICH I WILL PARTICIPATE ARE INHERENTLY DANGEROUS. THE INHERENT HAZARDS OF SUCH ACTIVITIES COULD CAUSE SERIOUS INJURY OR DEATH. I HEREBY AFFIRM THAT I AM VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES WITH FULL KNOWLEDGE AND ACCEPTANCE OF ALL DANGERS INVOLVED, AND AGREE TO ASSUME ANY AND ALL RISKS OF BODILY INJURY, DEATH OR PROPERTY DAMAGE, WHETHER THOSE RISKS ARE KNOWN OR UNKNOWN. I AFFIRM THAT I AM IN GOOD HEALTH AND THAT I HAVE NO MEDICAL OR PHYSICAL CONDITIONS THAT CAN, WILL OR MIGHT PREVENT MY SUCCESSFUL PARTICIPATION IN ANY TRAINING ACTIVITIES, AND I FURTHER AFFIRM THAT I PRESENTLY AM COVERED BY AN ADEQUATE HEALTH AND LIFE INSURANCE POLICIES THAT WILL COVER ANY INJURIES OR DEATH THAT I MIGHT SUFFER WHILE PARTICIPATING IN ANY TRAINING ACTIVITIES.**

In consideration for being permitted by the U.S. Army and any agency or employee of the U.S. Government ("U.S.G."), and any lessor/owner of the premises ("Lessor"), or the owner of any of equipment or facilities ("Affiliated Individuals or Organizations") required to participate in any Training and use or be on or in the premises and facilities wherein or whereon the Training will take place, I, the Participant/Releasor do hereby forever release the U.S.G., the Lessor, or any Affiliated Organizations, and their respective directors, officers, employees, volunteers, agents, contractors, and representatives (collectively "Releasees") from any and all actions, claims, or demands that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives now have, or may have in the future, for injury, death, or property damage, related to (i) my participation in these activities, (ii) the negligence or other acts, whether directly or indirectly connected to these activities, and however caused, by any Releasee, or (iii) the condition of the premises where these activities occur, whether or not I am then participating in the activities. I also agree that I, my assignees, heirs, legatees, distributees, guardians, next of kin, spouse and legal representatives waive any and all rights I might have to make a claim against, sue, or attach the property, personal or public, of any Releasee in connection with any of the matters covered by the foregoing release.

**I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF AND THE U.S.G., THE LESSOR, AND ANY AFFILIATED ORGANIZATIONS, AND RELEASEES AND SIGN IT KNOWINLGY, VOLUNTARILY AND OF MY OWN FREE WILL (OR ON BEHALF OF BOTH MYSELF AND MY MINOR CHILD), AND ASSUME ANY AN ALL RISKS OF AND LIABILITY FOR INJURY OR DEATH ASSOCIATED WITH OR ARISING FROM MY PARTICIPATION IN ANY TRAINING ACTIVITIES.**

**If Signed by Parent or Guardian:** I verify, affirm and acknowledge that the dangers of the activities and the significance of this Release and Waiver were explained to both myself and the Participant/Releasee, to my satisfaction, and that both I and the Participant/Releasee understand and consent to risking them.

Executed at _____, _____ on _____, 2_____.
City State Day Year

PARTICIPANT/RELEASOR AGREEMENT

CADET Bobby Joe
Printed Name:

Signature:

Address: YOUR ADDRESS

PARENT OR GUARDIAN AGREEMENT

MY PARENT
Printed Name:

Signature:

Address: PARENTS ADDRESS

**IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE, PARTICIPANT'S PARENT OR GUARDIAN MUST SIGN THIS FORM WHERE INDICATED.**

**Authorized agent of the U.S.G., the Lessor, any Affiliated Organizations, and the Releasees:**

| Printed Name: | Position: | Signature: | Date: |
|---|---|---|---|
| | | | |

THIS FORM MUST BE NOTARIZED

THIS CAN BE DONE AT THE FRONT OFFICE (BRING A PICTURE ID

C

## JCLC IN/OUT PROCESSING

Last name, First, MI: LAST NAME, FIRST NAME SSN: X

Address: YOUR ADDRESS City: YOUR CITY

State: FLORIDA Zip Code: 33458

School: JUPITER Let Level: YOUR CURRENT LET LEVEL

DOB: DAY MONTH YEAR OF BIRTH

**Unit of Assignment:**

Company: LEAVE BLANK Platoon: Squad:

Cadre Institutional Representative:

**Person to be notified in case of emergency:**

Name and relationship: CONTACT INFO FOR EMERGENCIES

Address: City:

State: FLORIDA Zip Code: 33458

School: JUPITER Let Level: YOUR CURRENT LET LEVEL

Date In-processed: LEAVE

Date Out-processed:

Covenant Not to Sue for JCLC on File: BLANK

Special Power of Attorney on File (as needed):

D

## CADET INFORMATION

## STATEMENT REQUIRED BY PRIVACY ACT OF 1974

1. **AUTHORITY**: Title 10, U.S. Code 2102

2. **PRINCIPAL PURPOSE(S)**: To gather information, emergency points of contact, and statement of the physical condition of JROTC Cadets attending JCLC.

3. **ROUTINE USES**: Normal Personnel Actions—Disclosures of information may be provided to proper authorities in actions regarding medical treatment, legal actions, investigation of accidents, and preparation of statistics and training records resulting from JCLC.

4. **MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION**: Disclosure is voluntary. Failure of Cadet to complete form will disqualify JROTC Cadet from participating in JCLC.

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1. **Cadet**: YOUR NAME
(Rank, Last Name, First, MI)

2. X
(SSN)

JUPITER HS
(Name of School)

3. I will attend JCLC during ( ) First Cycle or ( ) Second cycle

4. **Parent or Guardian** PARENT NAME & ADDRESS
(Name and Address)

5. Telephone: PARENT PHONE Other: _____

6. **Family Doctor:** YOUR DOCTOR INFO
(Name and Address)

7. Telephone: _____ Other: _____

8. **Dentist:** YOUR DENTIST INFO
(Name and Address)

9. Telephone: _____ Other: _____

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**NOTE: IF PARENT OR GUARDIAN CANNOT BE CONTACTED, PLEASE LIST ONE OTHER PERSON TO CONTACT IN CASE OF AN EMERGENCY.**

10. **Emergency Contact**: EMERGENCY CONTACT NAME

E

(Name and Address)

11. Telephone: PARENTS PHONE NUMBER Other: _____

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(____) ← PARENT INITIALS
Initials

**STATE OF PHYSICAL CONDITION**

**To the best of my knowledge, my son/daughter/ward is in good physical condition. Participation in JCLC, in my opinion, will not have an adverse effect on his/her health and well-being. I will inform the JCLC Commander of any changes.**

(____) ← PARENT INITIALS
Initials

My son/daughter/ward has a history of (identify illnesses; Heart disease, Asthma, Overweight, Sinus, Rheumatic Fever, Ear Infection, Headaches, or any other ailments) LIST ANY AILMENTS OR LEAVE BLANK and is on LIST MEDICATION medication. He/she is allergic to the following medication: LIST ANY ALLERGIES OR LEAVE BLANK.

**NOTE:** Students that are found to have previous history of any type illness, past injury, and/or symptoms of suspected medical aliment, will be returned home if treatment is needed or desired.

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**DENTAL RECORDS**

I acknowledge my dental records contain detail profiles and/or x-rays of sufficient detail for identification.

I (do) (do not) have a dentist or dental records.

CADET SIGNATURE
(Signature of Cadet/Parent/Guardian)

PARENT SIGNATURE
(Signature of Cadet/Parent/Guardian)

F

## CONSENT TO MEDICAL TREATMENT

**STATEMENT REQUIRED BY PRIVACY ACT OF 1974**

**(1) AUTHORITY: TITLE 10, U.S. CODE 2102.**
**(2) PRINCIPAL PURPOSES:** A statement authorizing medical care in civilian or government medical facilities while attending or traveling to or from JCLC.
**(3) ROUTINE USES:** Normal personnel actions: Disclosure of information may be provided to proper authorities in actions regarding medical treatment, legal actions as a result of injury or death, and investigation of accident resulting from JCLC.
**(4) MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION:** Voluntary. Failure to complete form will disqualify JROTC Cadet from participating in specific voluntary training exercises.

I PARENTS PRINTED NAME, consent to be treated in an Army Hospital, or any other government or civilian medical facility, near or en-route to JCLC, FLORIDA (Installation, State) while attending or traveling to or from JCLC from JUNE (MM/YY).

This consent encompasses all procedures and treatments as are found to be necessary or desirable, in the judgment of the professional staff of any of the above-named medical facilities. I understand that this consent is of a general nature and accordingly list the following exceptions to this consent (if no exceptions write "No Exceptions")

NO EXCEPTIONS, OR LIST ANY EXEPTIONS

I (am) (am not) on medication. (List type, if on medication)

I (am) (am not) allergic to medication. (List type, if allergic)

CIRCLE AM OR AM NOT

It is understood that this consent can be withdrawn in writing or orally at anytime.

WITNESS SIGNATURE
Signature of Witness

CADET SIGNATURE
Signature of Cadet

WITNESS NAME
Print Name of Witness

NAME OF CADET SSN XXX
Print Name of Cadet

PARENT OR GUARDIAN: (When Cadet is a minor or unable to give consent), I _____, parent/guardian of _____ have read and understood the above consent to treatment and hereby expressly consent to the above-described treatment.

_____
Signature of Witness

_____
Print Name of Witness

NOTARY

PARENT SIGNATURE
Signature of Parent

NAME OF PARENT SSN XXX
Print Name of Parent

THIS FORM MUST BE NOTARIZED

THIS CAN BE DONE AT THE FRONT OFFICE (BRING A PICTURE ID)

G

## CONVENANT NOT TO SUE
## OFF-CAMPUS TRAINING AND PRACTICAL FIELD/HIGH RISK TRAINING

**(1) AUTHORITY:** Title 10, U.S. Code 23-1.
**(2) PRINCIPAL PURPOSE(S):** To release the U.S. Government, the host institution and the state in which said institution is located from liability for injury; death, or damages for JROTC cadets participating in voluntary off-campus training programs, practical field, and high risk training.
**(3) ROUTINE USES:** Normal personnel actions. Disclosures of information may be provided to proper authorities in actions regarding law enforcement, legal actions as a result of injury or death, and investigations of accidents resulting from such voluntary off-campus training, practical field, and high-risk training.
**(4) MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION:** Voluntary. Failure to complete form will disqualify JROTC cadet from participating in specific voluntary training exercises.

I CADET NAME, residing at CADET ADDRESS
(Type or print full name) (Address) (City)

do hereby agree that in consideration for being allowed to participate in JCLC,

conducted by JUPITER HS School Army JROTC detachment, and Army
(Name of JROTC Instructor Group)

supervised activity, and whereas I am doing so entirely on my own initiative, risk, and responsibility; and being fully aware of the risk adhering to this type of training, I hereby RELEASE AND DISCHAGE FOREVER, the United States Army, the State of FLORIDA and JUPITER high and all of its officers, agents, and employees, acting officially or (Name of School)

from any and all claims demands, actions or causes of action, on account of myself OR on account of any injury to me which may occur from any cause during said activity or continuances thereof, and I do further covenant and agree to hold the said Government of the United States, State of FLORIDA

_____ and all of its officers, agents, and employees, acting officially or otherwise, blameless for any and all damages which I may cause either intentionally or thru my negligence.

NAME
Typed/Printed Name of Parent or Guardian if Participant is a Minor

Signature of Parent or Guardian if Participant is a Minor

MOM/DAD/UNCLE/AUNT
Relationship to Cadet

DATE SIGNED
Date

WITNESSED BY:

AGE OF CADET
Age/Period Covered

SIGNATURE
Signature of Cadet

**(Figure J-4 JCLC – Covenant not to Sue)**

H

EL2

Revised 03/10

Florida High School Athletic Association

# Preparticipation Physical Evaluation (Page 1 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

## Part 1. Student Information (to be completed by student or parent)

Student's Name: _____ Sex: ____ Age: ____ Date of Birth: ____/____/____

School: _____ Grade in School: ____ Sport(s): _____

Home Address: _____ Home Phone: (____)_____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Personal/Family Physician: _____ City/State: _____ Office Phone: (____)_____

## Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

| | | Yes | No |
|---|---|---|---|
| 1 | Have you had a medical illness or injury since your last check up or sports physical? | ___ | ___ |
| 2. | Do you have an ongoing chronic illness? | ___ | ___ |
| 3. | Have you ever been hospitalized overnight? | ___ | ___ |
| 4. | Have you ever had surgery? | ___ | ___ |
| 5. | Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ |
| 6. | Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | ___ | ___ |
| 7. | Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? | ___ | ___ |
| 8. | Have you ever had a rash or hives develop during or after exercise? | ___ | ___ |
| 9. | Have you ever passed out during or after exercise? | ___ | ___ |
| 10. | Have you ever been dizzy during or after exercise? | ___ | ___ |
| 11. | Have you ever had chest pain during or after exercise? | ___ | ___ |
| 12. | Do you get tired more quickly than your friends do during exercise? | ___ | ___ |
| 13. | Have you ever had racing of your heart or skipped heartbeats? | ___ | ___ |
| 14. | Have you had high blood pressure or high cholesterol? | ___ | ___ |
| 15. | Have you ever been told you have a heart murmur? | ___ | ___ |
| 16. | Has any family member or relative died of heart problems or sudden death before age 50. | ___ | ___ |
| 17. | Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ___ | ___ |
| 18. | Has a physician ever denied or restricted your participation in sports for any heart problems? | ___ | ___ |
| 19. | Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? | ___ | ___ |
| 20. | Have you ever had a head injury or concussion? | ___ | ___ |
| 21. | Have you ever been knocked out, become unconscious or lost your memory? | ___ | ___ |
| 22. | Have you ever had a seizure? | ___ | ___ |
| 23. | Do you have frequent or severe headaches? | ___ | ___ |
| 24. | Have you ever had numbness or tingling in your arms, hands, legs or feet? | ___ | ___ |
| 25. | Have you ever had a stinger, burner or pinched nerve? | ___ | ___ |
| 26. | Have you ever become ill from exercising in the heat? | ___ | ___ |
| 27. | Do you cough, wheeze or have trouble breathing during or after activity? | ___ | ___ |
| 28. | Do you have asthma? | ___ | ___ |
| 29. | Do you have seasonal allergies that require medical treatment? | ___ | ___ |
| 30. | Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)? | ___ | ___ |
| 31. | Have you had any problems with your eyes or vision? | ___ | ___ |
| 32. | Do you wear glasses, contacts or protective eyewear? | ___ | ___ |
| 33. | Have you ever had a sprain, strain or swelling after injury? | ___ | ___ |
| 34. | Have you broken or fractured any bones or dislocated any joints? | ___ | ___ |
| 35. | Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | ___ | ___ |

*If yes, check appropriate blank and explain below:*

| | | |
|---|---|---|
| ___ Head | ___ Elbow | ___ Hip |
| ___ Neck | ___ Forearm | ___ Thigh |
| ___ Back | ___ Wrist | ___ Knee |
| ___ Chest | ___ Hand | ___ Shin/Calf |
| ___ Shoulder | ___ Finger | ___ Ankle |
| ___ Upper Arm | ___ Foot | |

| | | | |
|---|---|---|---|
| 36. | Do you want to weigh more or less than you do now? | ___ | ___ |
| 37. | Do you lose weight regularly to meet weight requirements for your sport? | ___ | ___ |
| 38. | Do you feel stressed out? | ___ | ___ |
| 39. | Have you ever been diagnosed with sickle cell anemia? | ___ | ___ |
| 40. | Have you ever been diagnosed with having the sickle cell trait? | ___ | ___ |

41. Record the dates of your most recent immunizations (shots) for:
Tetanus: _____ Measles: _____
Hepatitus B: _____ Chickenpox: _____

**FEMALES ONLY (optional)**

42. When was your first menstrual period? _____
43. When was your most recent menstrual period? _____
44. How much time do you usually have from the start of one period to the start of another? _____
45. How many periods have you had in the last year? _____
46. What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___



TO BE COMPLETED AT A PHYSICIAN'S OFFICE

EL2

Revised 03/10

Florida High School Athletic Association

# Preparticipation Physical Evaluation (Page 2 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2.

**Part 3. Physical Examination** (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: ____/____ (____/____, ____/____)

Temperature: _____ Hearing: right: P_____ F_____ left: P_____ F_____

Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes No Pupils: Equal _____ Unequal _____

| FINDINGS | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|---|---|---|---|
| MEDICAL | | | |
| 1. Appearance | | | |
| 2. Eyes/Ears/Nose/Throat | | | |
| 3. Lymph Nodes | | | |
| 4. Heart | | | |
| 5. Pulses | | | |
| 6. Lungs | | | |
| 7. Abdomen | | | |
| 8. Genitalia (males only) | | | |
| 9. Skin | | | |
| MUSCULOSKELETAL | | | |
| 10. Neck | | | |
| 11. Back | | | |
| 12. Shoulder/Arm | | | |
| 13. Elbow/Forearm | | | |
| 14. Wrist/Hand | | | |
| 15. Hip/Thigh | | | |
| * 16. Knee | | | |
| 17. Leg/Ankle | | | |
| 18. Foot | | | |

* – station-based examination only

SIGNATURE OF EXAMINER: PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

____ Precautions: _____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

YOUR Doctor MUST CHECK CLEARED