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 _____

Name - Last, First, MI _____ _____ _____ __

Home Address _____

Student Number _____ **Grade** _____ **LET Level** _____

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

_____ / _____ / _____
_____ / _____ / _____
_____ / _____ / _____

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

_____
_____

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 /# _____ **/ Name /#** _____

Signature of Parent or Legal Guardian **Date**

_____ _____

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 _____ (City), _____ (State) on _____ (Date), 2_____ (Year).

PARTICIPANT/RELEASOR AGREEMENT

Printed Name: _____

Signature: _____

Address: _____

_____

PARENT OR GUARDIAN AGREEMENT

Printed Name: _____

Signature: _____

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:
_____	_____	_____	_____

C

JCLC IN/OUT PROCESSING

Last name, First, MI: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip Code: _____

School: _____ Let Level: _____

DOB: _____

Unit of Assignment:

Company: _____ Platoon: _____ Squad: _____

Cadre Institutional Representative: _____

Person to be notified in case of emergency:

Name and relationship: _____

Address: _____ City: _____

State: _____ Zip Code: _____

School: _____ Let Level: _____

Date In-processed: _____

Date Out-processed: _____

Covenant Not to Sue for JCLC on File: _____

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:** _____
(Rank, Last Name, First, MI)

2. _____ _____
(SSN) (Name of School)

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

4. **Parent or Guardian** _____
(Name and Address)

5. Telephone: _____ Other: _____

6. **Family Doctor:** _____
(Name and Address)

7. Telephone: _____ Other: _____

8. **Dentist:** _____
(Name and Address)

9. Telephone: _____ Other: _____

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

10. **Emergency Contact:** _____

(Name and Address)

11. Telephone: _____ Other: _____

STATE OF PHYSICAL CONDITION

(____)
Initials

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.

(____)
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) _____,

and is on _____medication. He/she is allergic to the

following medication: _____.

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.

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.

_____ _____
(Signature of Cadet/Parent/Guardian) (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 _____, consent to be treated in an Army Hospital, or any other government

or civilian medical facility, near or en-route to _____,
(Installation, State)

while attending or traveling to or from JCLC from _____.
(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")

_____,_____.

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

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

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

_____ _____
Signature of Witness Signature of Cadet

_____ _____ SSN _____
Print Name of Witness 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 Signature of Parent

_____ _____ SSN _____
Print Name of Witness Print Name of Parent

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_____, residing at_____,_____
(Type or print full name) (Address) (City)

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

conducted by _____ 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 _____ and _____ 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 _____, _____

_____ 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.

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

_____
Signature of Parent or Guardian if Participant is a Minor

_____
Relationship to Cadet

_____
Date

WITNESSED BY:

_____
Age/Period Covered

_____
Signature of Cadet

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

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: _____
Hepatitis 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: ___/___/___

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

ASSESSMENT OF EXAMINING 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 _____ For: _____

Recommendations: _____

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

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____