

CADET ACTIVITY MEDICAL INFORMATION FORM

INSTRUCTIONS: All activity participants must complete this form in its entirety. Indicate NONE or NO where applicable. Failure to disclose all known medical conditions is cause for dismissal from the activity. Attach a current copy of the member's insurance card to the application submission. Parent/guardian of cadets age 17 and under must complete this form.

PART I – MEMBER & EMERGENCY CONTACT INFORMATION

CAPID	NAME (Last, First, MI)	DATE OF BIRTH	UNIT CHARTER NUMBER
PRIMARY PHONE	ALTERNATE PHONE	E-MAIL	
FIRST EMERGENCY CONTACT NAME	RELATIONSHIP	PRIMARY PHONE (Emergency)	ALTERNATE PHONE (Emergency)
SECOND EMERGENCY CONTACT NAME	RELATIONSHIP	PRIMARY PHONE (Emergency)	ALTERNATE PHONE (Emergency)
HOME ADDRESS (First Emergency Contact)	CITY	STATE	ZIP CODE

PART II – INSURANCE INFORMATION

INSURANCE COMPANY	POLICY / ID NUMBER	PHONE NUMBER
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PART III – MEDICATION INFORMATION & AUTHORIZED NON-PRESCRIPTION MEDICATION

INSTRUCTIONS: List ALL prescription, over-the-counter (OTC), and herbal medications taken. Include medication name, dosage, and time to be given. ALL medications MUST be in the original container. DO NOT bring any medications in daily pill packs. For cadets 17 and under, indicate which over-the-counter medicines, their generics, or a similar product if necessary or deemed appropriate by the health services officer may be given. No product endorsement is implied. INITIAL next to each OTC medication authorized.

MEDICATION (ex. Conerta 27mg)	DOSAGE (ex. 1 tablet)	TIME GIVEN (ex. Every AM)	REASON FOR MEDICATION (ex. ADHD)	SPECIAL HANDLING INSTRUCTIONS (ex. Must keep refrigerated)

Permission for Administration of Non-Prescription Medications. Non-prescription medications may be given to minor cadets as needed and according to package directions by CAP senior members, and only if permission is given in writing by the cadet's parent or guardian. I hereby grant permission to the Civil Air Patrol and the Health Services Officers of this activity to administer the medications indicated below to my cadet/child during this activity after consultation and as directed by myself (initial next to each medication authorized).

<input type="checkbox"/> Acetaminophen (Tylenol®)	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Diphenhydramine (Benadryl®)	<input type="checkbox"/> Calamine Lotion®
<input type="checkbox"/> Pseudoephedrine	<input type="checkbox"/> Antacids	<input type="checkbox"/> Cough/Cold Products	<input type="checkbox"/> Anesthetic throat spray
<input type="checkbox"/> Midol®	<input type="checkbox"/> Pepto-Bismol®	<input type="checkbox"/> Anti-diarrheal products	<input type="checkbox"/> Antibiotic Ointments
<input type="checkbox"/> Other:			

PART IV – MEDICAL HISTORY & INFORMATION

Has the member had, or currently have, any of the following? Circle Y for yes, N for no. *If yes, explain in the remarks section with date and physicians consulted.*

Y N Frequent Headaches	Y N Heart Trouble	Y N Motion Sickness	Y N Broken Bones	Y N Stomach Trouble
Y N Dizziness or Fainting	Y N Ear Infections	Y N Nervous Trouble	Y N Attempt Suicide	Y N Drug or Alcohol Habit
Y N Unconsciousness	Y N Hernias	Y N Chronic Diseases	Y N High Blood Pressure	Y N Medical Treatment
Y N Asthma	Y N Positive TB Skin Test	Y N Menstrual Cramps	Y N Low Blood Pressure	
Y N Hay Fever	Y N Epilepsy or Seizures	Y N Known Allergies	Y N Eye Trouble <i>except glasses</i>	Y N Other (List in Remarks)
Y N Diabetes	Y N Kidney Stones	Y N Admitted to a Hospital	Y N Chronic Injuries	

Y | N The member has been or is now waived from physical training by a doctor. Y | N Is there anything else not specifically listed that should be known?

REMARKS. Describe all medications being taken, medical ailments, recent accidents and injuries, other accidents and injuries, and other conditions.

ALLERGY INFORMATION. List any allergies to medications, food, insects, etc.

DIETARY RESTRICTIONS. Medical, religious, vegetarian, etc.

PART V – MEMBER OR PARENT/GUARDIAN CERTIFICATION & CONSENT

I hereby grant permission for the activity Health Services Officer to share this information with CAP Senior Staff members and any health care providers as necessary to ensure appropriate healthcare services are provided for my cadet/child (or myself if age 18 or over). I (DO) (DO NOT) (*circle DO or DO NOT – ~~line through other~~*) authorize the health services staff to collect and safeguard my minor cadet's medication for the duration of the activity.

PARENT/GUARDIAN NAME (OR MEMBER OVER 18) (TYPED)	PARENT/GUARDIAN SIGNATURE (OR MEMBER OVER 18)	DATE
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