

APPLICATION FOR CAP ENCAMPMENT OR SPECIAL ACTIVITY

Name <i>(Last, First, Middle)</i>			CAPID	CAP Grade	Gender
Member Type	Charter No. (e.g. GLR-MI-059)		Grade in School	Religious Preference	
Address (Include No., Street, City, State and Zip Code)			Home Phone Number	Cell Phone Number	
			E-Mail Address		
Date of Birth (mm/dd/yy)	Shirt Size	Height (Inches)	Weight (Lbs)	Hair Color	Eye Color
Title of Activity		Location of Activity	Activity Dates		
Staff Position(s) Sought					
Emergency Contact Information					
(Primary Contact) Name (Last, First, Middle Initial)			Relationship	Primary Phone Number	
(Secondary Contact) Name (Last, First, Middle Initial)			Relationship	Primary Phone Number	

RELEASE AGREEMENT

KNOW ALL MEN BY THESE PRESENTS that I am submitting my application for Civil Air Patrol Special Activities or Encampments, and I hereby volunteer entirely upon my own initiative, risk, and responsibility for an assignment to participate in this activity of encampment at the first available opportunity and with full knowledge that such activity may include:

1. Traveling by land, sea, or air in US military, commercial, or privately owned vehicles from regular place or residence to the site of the activity or encampment, travel incident to the activity or encampment, and subsequent return to place of residence.
2. Participation in aeronautical activities as a passenger or student trainee in US military, commercial, or privately owned aircraft.
3. Living for a period of one week or more on diminished rations and minimal shelter simulating actual survival conditions.
4. Being quartered and/or subsisting away from regular or normal place of residence for an extended period of time.
5. Remaining with the cadet group I am assigned to at all times during the activity or encampment.
6. Acting as a spokesman for Civil Air Patrol, rendering reports on the activity or encampment.
7. Refraining from argumentative discussions concerning governmental policies.

In consideration of the permission extended to me by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity/encampment or activities/encampments, I do hereby for myself, my heirs, executors, and administrators release and forever discharge the Civil Air Patrol, Inc./United States of America, and all its officers, agents, and employees acting official or otherwise, from any and all claims, demands, actions, or causes of action, on account of my death or on account of any injury to me or my property which may occur as a result of the negligence of the Civil Air Patrol/United States of America, its agents or employees during said activity/encampment or activities/encampments or continuances thereof, as well as all ground and flight operations incident thereto.

_____ Date

_____ Signature of Applicant

Name (Last, First, Middle)	Title of Activity
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RELEASE BY PARENTS OR GUARDIAN

KNOW ALL MEN BY THESE PRESENTS: WHEREBY my child has applied for the activity or encampment referred to above, In consideration of the permission extended to my child by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity/encampment or activities/encampments, I do hereby for myself, my heirs, executors, and administrators release and forever discharge the Civil Air Patrol, Inc./United States of America, and all its officers, agents and employees acting official or otherwise, from any and all claims, demands, actions or causes of action, on account of the death or on account of any injury to my child which may occur as a result of the negligence of the Civil Air Patrol/United States of America, its agents or employees during said activity/encampment or activities/encampments or continuances thereof, as well as all ground and flight operations incident thereto. In addition, by my signature below, I certify the applicant:

1. Is my minor child or ward.
2. Has no history or injury or disease which might be affected by this activity except those previously noted in the Medical Information section of this form.
3. Will follow all rules, regulations, and directives as established by the Civil Air Patrol, Inc., activity project officer or encampment commander, or other staff members. If not following the above mentioned rules, regulations, and directives he/she may be sent home at the discretion of the project officer, encampment commander or activity directory at my expense.

However, in case of injury, disease or other illness, permission is hereby granted to treat the applicant as required, and if the applicant is released from the activity before recovery from said injury, disease, or illness, further treatment will be provided by myself.

Date

Witness for Father's Signature

Father or Legal Guardian

Witness for Mother's Signature

Mother or Legal Guardian

Squadron Certification. (Squadron Commander's signature is not necessary if the activity is approved in eServices or if it is a squadron activity.)

I certify that the above information is correct and that all requirements for attendance, as specified in National Headquarters Directives, will be completed by the required dates.

Date

Squadron Commander

Group Certification. (Group Commander's signature is not necessary if the activity is approved in eServices or if the activity is held within the group.)

Date

Group Commander (or designee)

Wing Certification. (Wing Commander's signature is not necessary if the activity is approved in eServices or if the activity is held within the wing.)

Date

Wing Commander (or designee)

CAP MEMBER HEALTH HISTORY FORM

This information is CONFIDENTIAL and for official use only. It cannot be released to unauthorized persons. Answer all questions as accurately as possible so that the activity or encampment staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you. This form will also provide medical information in a case when you are unable to do so.

Name <i>(Last, First, Middle)</i>			Grade	CAPID	Charter Number
Date of Birth <i>(mm/dd/yy)</i>	Height	Weight	Hair Color	Eye Color	Gender

Allergies: List Names of Medication or Other Allergies (*i.e., bee sting, food, plants*) and types of reactions; please note food allergy details with dietary restrictions below on back as well.

Do You Now Have Or Have You Ever Had Any Of The Following? *Explain any yes' in the remarks section below or attach additional sheet. Conditions not specifically noted below having the potential to interfere with performance during the special activity or encampment should be documented in the remarks section.)*

If "Yes" is marked in an item with multiple choices, please circle which problem applies.

No	Yes		No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Decreased vision, glaucoma, contacts	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurring injuries
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections, perforation	<input type="checkbox"/>	<input type="checkbox"/>	Activity, mobility restrictions
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty equalizing ears	<input type="checkbox"/>	<input type="checkbox"/>	Use of cane, walker, wheelchair
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss, hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Back or neck pain or injury
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	Migraine or severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis, serious allergic reaction	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, emphysema (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Head injury, unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	Ever use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizure
<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath with activity	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, chest pain, angina	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems (low or high)
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur, heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, high or low blood sugars
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Irregular or rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease, hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness
<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble, ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Special diet, food allergies
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Current bedwetting problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea, constipation	<input type="checkbox"/>	<input type="checkbox"/>	ADD (Attention Deficit Disorder)
<input type="checkbox"/>	<input type="checkbox"/>	Hernia or rupture	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness (bipolar, other)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression, anxiety, suicidal
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems (men)	<input type="checkbox"/>	<input type="checkbox"/>	Admission to the hospital
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Other chronic medical illnesses
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps (women)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder, sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	Broken bone, joint problems	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury

Dietary Restrictions or Limitations (*List any dietary restrictions like food allergies, diabetes, gluten-free, vegetarian diets, etc.*)

Past Surgical History (*List all surgeries including tonsils, ear tubes, appendix, gall bladder, hernia, hysterectomy, heart, heart catheterization, bone and joint and all other surgeries.*)

Date Tetanus Booster
 No Td or Tdap
 Date:

Hepatitis Vaccine
 No
 Date:

Pneumonia Vaccine
 No
 Date:

Varicella Immunization/chickenpox
 No
 Date:

Influenza Vaccine
 No
 Date:

Medication Information - *Include supplements, over-the-counter medicines, herbals, creams, etc., or write "None".*

Name of Medication/Inhaler	Tablet Strength	Times taken per day	Reason for Medication	Any Special Dosing or Storage Instructions (i.e., as needed, with meals, must be refrigerated, etc.)
1.				
2.				
3.				
4.				

Social History

Tobacco Use (*packs per day, years smoked, smokeless tobacco use*)

Occupation (*student or other*)

Religious Preference

Remarks (*Attach additional sheet if needed*)

CONSENT FOR MINOR CADET PARTICIPATION, MEDICATIONS, TREATMENT

I give permission for full participation in CAP programs, subject to any limitations noted herein.

My signature below evidences my consent for my child/ward to possess and self-administer the prescription medications listed above. I understand that there are legal limitations imposed on CAP senior members with regard to the involuntary administration of medications to my child/ward. (Cross out if permission is denied).

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge exam/test results and treatment provided.

DATE

SIGNATURE OF PARENT/GUARDIAN

EMERGENCY INFORMATION (Insurance/Physician Information, Emergency Contacts, Minor Consents)				
Name <i>(Last, First, Middle)</i>		Grade	CAPID	Charter Number
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
<i>(Area Code)</i> Home Phone		<i>(Area Code)</i> Cell Phone		
Primary Insurance Information <i>(Please attach copy of insurance cards, front and back)</i>				
Medical Insurance Company	Policy Number	Group Code/Number	Co-Pay Amount \$	
Prescription Coverage Company	Policy Number	Group Code/Number	Co-Pay Amount \$	
Family Physician				
Name			<i>(Area Code)</i> Phone	
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
Emergency Contact <i>(Parent, guardian or closest relative to be notified in case of emergency)</i>				
Name			Relationship to Applicant	
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
<i>(Area Code)</i> Pager	<i>(Area Code)</i> Cell/Mobile Phone	<i>(Area Code)</i> Day Phone	<i>(Area Code)</i> Night Phone	
Unit Commander Name and Grade		Unit Name		
<i>(Area Code)</i> Unit Commander Day Phone		<i>(Area Code)</i> Unit Commander Night Phone		

PERMISSION FOR PROVISION OF MINOR CADET OVER-THE-COUNTER MEDICATION

This form may not be usable in some states due to statutes concerning who can administer medications and administration conditions. Wings with such restrictions will publish appropriate additional guidance in a supplement to CAPR 160-1.

Name <i>(Last, First, Middle)</i>	Grade	CAPID	Charter Number
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Over-The Counter/Non-Prescription Medications

The following over-the counter medications may be administered according to package directions by CAP senior members. Cross out any medications not approved.

Acetaminophen (Tylenol) for fever or pain	Visine eye drops for dry, irritated eye relief
Ibuprofen (Advil, Motrin) for fever or pain	Op-Con A eye drops for allergic conjunctivitis
Bacitracin or Neosporin antibiotic ointment to prevent infection	Benadryl liquid/tabs for allergic reactions
Hydrocortisone anti-inflammatory rash cream	Claritin antihistamine for seasonal allergies
Calamine/Caladryl for poison ivy itch relief	Robitussin products for relief of cough and cold symptoms
Antifungal creams and sprays for treatment of fungal rashes	Delsym to suppress cough
	Tums or Maalox for relief of stomach upset

Allergies

My child/ward has the following allergies or reactions to over-the-counter medications (list type of reaction):

Consent For Minor Cadet To Receive Over-The-Counter Medications

My signature below evidences my consent for CAP senior members to provide over-the-counter non-prescription medications (such as those listed above) to my child/ward if indicated in the reasonable judgment of such senior members. I understand that I will be informed if any such medications are administered.

Date	Signature of Parent/Guardian
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