APPLICATION FOR CAP ENCAMPMENT OR SPECIAL ACTIVITY

This application is used for Wing Encampments and National Cadet Special Activities (NCSA/CSA) only.
Local versions may be used. For all other activities, use CAPF 60-80.

Name (Last, First, Middle Initial)		**CAPID**	**CAP Grade**	**Gender**
Member Type	**Charter No. (e.g. GLR-MI-059)**	**Date of Birth**	**Shirt Size**	
Address (Include No., Street, City, State and Zip Code)		**Height (inches)**	**Weight (lbs)**	
		E-Mail Address		
Home Phone Number	**Cell Phone Number**	**Parent or Guardian E-Mail Address**		
Title of Activity	**Location of Activity**	**Activity Dates**		
Staff Position(s) Sought				

Applicant Signature

I hereby submit my application and ask to be considered for the above activity. I certify that the above information is correct and that all requirements for attendance will be completed by the required date.

Date _____ Signature of Applicant _____

Release by Parent or Guardian

Not required for cadets who have reached the age of majority.
For special activities using eServices registration, parent signature obtained after cadet is offered a slot at activity.

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 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 is my minor child or ward and they 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 my child does not follow 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 _____ Parent or Legal Guardian Signature _____

Squadron Certification

I hereby endorse this application and will support the cadet's participation if selected. I certify that the above information is correct and that all requirements for attendance will be completed by the required dates.

Date _____ Squadron Commander _____

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 *(Last, First, Middle)*			**Grade**	**CAPID**	**Charter Number**
Date of Birth (mm/dd/yy)	**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	
☐	☐	Decreased vision, glaucoma, contacts	☐	☐	Chronic or recurring injuries
☐	☐	Ear infections, perforation	☐	☐	Activity, mobility restrictions
☐	☐	Difficulty equalizing ears	☐	☐	Use of cane, walker, wheelchair
☐	☐	Hearing loss, hearing aid	☐	☐	Back or neck pain or injury
☐	☐	Allergies, nasal stuffiness	☐	☐	Migraine or severe headaches
☐	☐	Anaphylaxis, serious allergic reaction	☐	☐	Dizziness or fainting spells
☐	☐	Asthma, emphysema (COPD)	☐	☐	Head injury, unconsciousness
☐	☐	Ever use an inhaler	☐	☐	Epilepsy or seizure
☐	☐	Short of Breath with activity	☐	☐	Stroke, paralysis
☐	☐	Heart Attack, chest pain, angina	☐	☐	Thyroid problems (low or high)
☐	☐	Heart murmur, heart problems	☐	☐	Diabetes, high or low blood sugars
☐	☐	Congestive heart failure	☐	☐	Cancer, leukemia
☐	☐	Irregular or rapid heartbeat	☐	☐	Blood disease, hemophilia
☐	☐	High or low blood pressure	☐	☐	Motion sickness
☐	☐	Stomach trouble, ulcers	☐	☐	Special diet, food allergies
☐	☐	Hepatitis or liver problems	☐	☐	Current bedwetting problems
☐	☐	Diarrhea, constipation	☐	☐	ADD (Attention Deficit Disorder)
☐	☐	Hernia or rupture	☐	☐	Mental illness (bipolar, other)
☐	☐	Kidney disease or stones	☐	☐	Depression, anxiety, suicidal
☐	☐	Prostate problems (men)	☐	☐	Admission to the hospital
☐	☐	Frequent urination	☐	☐	Other chronic medical illnesses
☐	☐	Menstrual cramps (women)	☐	☐	Sleep disorder, sleep apnea
☐	☐	Broken bone, joint problems	☐	☐	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 Immuni-zation/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 *(Last, First, Middle)*	**Grade**	**CAPID**	**Charter Number**
Mailing Address *(Number and Street)*	**City**	**State**	**Zip Code**
(Area Code) **Home Phone**	*(Area Code)* **Cell Phone**		

Primary Insurance Information *(Please attach copy of insurance cards, front and back)*

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	*(Area Code)* **Phone**		
Mailing Address *(Number and Street)*	**City**	**State**	**Zip Code**

Emergency Contact *(Parent, guardian or closest relative to be notified in case of emergency)*

Name		**Relationship to Applicant**	
Mailing Address *(Number and Street)*		**City**	**State**	**Zip Code**
(Area Code) **Pager**	*(Area Code)* **Cell/Mobile Phone**	*(Area Code)* **Day Phone**	*(Area Code)* **Night Phone**
Unit Commander Name and Grade		**Unit Name**	
(Area Code) **Unit Commander Day Phone**		*(Area Code)* **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 *(Last, First, Middle)*	**Grade**	**CAPID**	**Charter Number**

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

Ibuprofen (Advil, Motrin) for fever or pain

Bacitracin or Neosporin antibiotic ointment to prevent infection

Hydrocortisone anti-inflammatory rash cream

Calamine/Caladryl for poison ivy itch relief

Antifungal creams and sprays for treatment of fungal rashes

Visine eye drops for dry, irritated eye relief

Op-Con A eye drops for allergic conjunctivitis

Benadryl liquid/tabs for allergic reactions

Claritin antihistamine for seasonal allergies

Robitussin products for relief of cough and cold symptoms

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**