

FLORIDA WING CADET ACTIVITY MEDICAL DISCLOSURE FORM

INSTRUCTIONS: A parent/guardian must complete this form in its entirety. Indicate NONE or NO were applicable. Failure to disclose all medical conditions is cause for possible dismissal from this activity. A COPY OF THE CADET'S IMMUNIZATION RECORD AND INSURANCE CARD MUST BE ATTACHED.

STAFF USE ONLY: List serious ALLERGIES. Red ink.

I. CADET INFORMATION																						
CADET'S NAME (<i>Last, First MI</i>)	DATE OF BIRTH	CAPID																				
CADET'S CONTACT																						
DAY PHONE:	EVENING PHONE:	ADDITIONAL PHONE:																				
II. PHYSICIAN INFORMATION																						
PRIMARY CARE PHYSICIAN NAME		PHYSICIAN'S PHONE NUMBER																				
III. EMERGENCY CONTACT INFORMATION																						
<i>Guardian or relative to be notified in case of an emergency</i>																						
GUARDIAN OR RELATIVE		RELATIONSHIP																				
CONTACT																						
DAY PHONE:	EVENING PHONE:	ADDITIONAL PHONE:																				
HOME ADDRESS																						
CITY		STATE	ZIP CODE																			
IV. INSURANCE INFORMATION																						
INSURANCE COMPANY		ID NUMBER	PHONE NUMBER																			
V. MEDICATION INFORMATION																						
<p>INSTRUCTION: List <u>ALL</u> prescription, over-the-counter, and herbal medications this cadet takes. Include medication name, dosage, and time to be given. <u>ALL</u> MEDICATIONS <u>MUST</u> BE IN THE ORIGINAL CONTAINER. <u>DO NOT</u> SEND ANY MEDICATIONS IN DAILY PILL PACKS.</p> <p>If no medication is required, please check NONE. <input type="checkbox"/> NONE</p>																						
Medication <small>(ex: Concerta 27mg)</small>	Dosage <small>(ex: 1 tablet)</small>	Time(s) given <small>(ex: every AM)</small>	Reason for medication <small>(ex: ADHD)</small>	Special Handling Instructions																		
<p>This cadet may be given the following over-the-counter (OTC) medicines, their generics, or a similar product if necessary or deemed appropriate by the Health Services Officer (HSO). No product endorsement is implied.</p> <p>INSTRUCTION: Parent/Guardian, please indicate your approval by initialing each OTC you allow to be given.</p> <table style="width: 100%; border: none;"> <tr> <td>_____ Acetaminophen (Tylenol®)</td> <td>_____ Ibuprofen</td> <td>_____ Diphenhydramine (Benadryl®)</td> </tr> <tr> <td>_____ Pseudoephedrine</td> <td>_____ Antacids</td> <td>_____ Cough/cold products</td> </tr> <tr> <td>_____ Mido®</td> <td>_____ Pepto-Bismol®</td> <td>_____ Anti-diarrheal products</td> </tr> <tr> <td>_____ Calamine lotion®</td> <td colspan="2">_____ Anesthetic throat spray (Chloraseptic®)</td> </tr> <tr> <td colspan="3">_____ Antibiotic ointments (eg, Triple Ointment®, Neosporin®, Bacitracin®)</td> </tr> <tr> <td colspan="3">_____ Other:</td> </tr> </table>					_____ Acetaminophen (Tylenol®)	_____ Ibuprofen	_____ Diphenhydramine (Benadryl®)	_____ Pseudoephedrine	_____ Antacids	_____ Cough/cold products	_____ Mido®	_____ Pepto-Bismol®	_____ Anti-diarrheal products	_____ Calamine lotion®	_____ Anesthetic throat spray (Chloraseptic®)		_____ Antibiotic ointments (eg, Triple Ointment®, Neosporin®, Bacitracin®)			_____ Other:		
_____ Acetaminophen (Tylenol®)	_____ Ibuprofen	_____ Diphenhydramine (Benadryl®)																				
_____ Pseudoephedrine	_____ Antacids	_____ Cough/cold products																				
_____ Mido®	_____ Pepto-Bismol®	_____ Anti-diarrheal products																				
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_____ Antibiotic ointments (eg, Triple Ointment®, Neosporin®, Bacitracin®)																						
_____ Other:																						
<p>As the listed parent/guardian named in this document, I hereby grant permission to the Civil Air Patrol and the Health Services Officers of this activity to administer the above medications to my cadet/child during this activity as directed.</p>																						
PARENT/GUARDIAN SIGNATURE _____			DATE _____																			

IV. MEDICAL HISTORY

LIST ALL MEDICAL CONDITIONS OR RECENT INJURIES *(If none, indicate such)*

HAS THE CADET HAD, OR CURRENTLY HAS, ANY OF THE FOLLOWING?

If yes, please explain in the remarks section with date and physicians consulted.

Y	N	DESCRIPTION	Y	N	DESCRIPTION	Y	N	DESCRIPTION	Y	N	DESCRIPTION
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diseases	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble (except glasses)
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	Chronic injuries
<input type="checkbox"/>	<input type="checkbox"/>	Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Pos. TB skin test	<input type="checkbox"/>	<input type="checkbox"/>	Known allergies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Been admitted to a hospital	<input type="checkbox"/>	<input type="checkbox"/>	Drug or alcohol habit
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Medical treatment in last 5 years
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	Attempt suicide	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Nervous trouble	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Blood pressure			

Remarks: Describe all medications being taken, medical ailments, recent accidents, other accidents, and other conditions. We need this to be as thorough as possible. Include a separate sheet of paper or use the back of this page if necessary.

LIST ANY ALLERGIES TO MEDICATIONS, FOOD, INSECT STINGS, ETC. BE SPECIFIC. *(If none, indicate such)*

LIST ANY DIETARY RESTRICTIONS (e.g. MEDICAL, RELIGIOUS, VEGETARIAN, ETC.). *(If none, indicate such)*

ARE YOU NOW OR HAVE YOU EVER BEEN WAIVED FROM PHYSICAL TRAINING BY A DOCTOR? *(If no, indicate such; If)*

No Yes (explain):

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THIS CADET? *(If no, indicate such; If)*

No Yes (explain):

REMINDER: Attach a copy of the cadet's immunization record and insurance card are attached.

As the listed parent/guardian named in this document, I hereby grant permission for the activity Health Services Officer (HSO) to share this information with CAP Senior Staff members and any health care providers as necessary to provide appropriate healthcare care for my cadet/child (or myself if, CAP senior member). I also grant permission for any CAP or non-CAP attending medical or nursing staff to share medical information with any CAP HSO as necessary to provide appropriate healthcare care for my cadet (or myself if, CAP senior member).

PARENT/GUARDIAN SIGNATURE

DATE

NOTIFICATION: This information is for official use only and will not be released to unauthorized persons. Answer all questions as accurately as possible so that activity staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you.