Military Adventure Camp

RECORD OF EMERGENCY DATA

CADET IDENTIFICATION DATA			
NAME *(Last, First, Middle)*			GENDER ☐ MALE ☐ FEMALE
HOME ADDRESS *(Street, City, County, State, Zip Code)*			
HOME PHONE NUMBER	CELL PHONE NUMBER	DATE OF BIRTH (YYYY/MM/DD)	SOCIAL SECURITY NUMBER
KNOWN ALLERGIES? ☐ YES ☐ NO *(If yes, explain)* ARE YOU TAKING ANY PRESCRIBED MEDICATIONS? ☐ YES ☐ NO *(If yes, explain)* ARE YOU TAKING ANY OVER-THE-COUNTER MEDICATIONS? ☐ YES ☐ NO *(If yes, explain)*			
ADDITIONAL EMERGENCY INFORMATION? ☐ YES ☐ NO *(If yes, explain)*			

CUSTODIAL PARENT / GUARDIAN INFORMATION			
NAME *(Last, First, Middle)*		RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*		EMPLOYER	
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER	EMAIL ADDRESS
NAME *(Last, First, Middle)*		RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*		EMPLOYER	
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER	EMAIL ADDRESS

EMERGENCY CONTACT INFORMATION

Please list a minimum of two individuals to be contacted in the event of an emergency when the parent is unavailable.

NAME *(Last, First, Middle)*	RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*	HOME PHONE NUMBER	WORK/CELL PHONE NUMBER
NAME *(Last, First, Middle)*	RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*	HOME PHONE NUMBER	WORK/CELL PHONE NUMBER
NAME *(Last, First, Middle)*	RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*	HOME PHONE NUMBER	WORK/CELL PHONE NUMBER

MEDICAL PROVIDER

PHYSICIAN'S NAME *(Last, First, Middle)*	OFFICE PHONE NUMBER
OFFICE ADDRESS *(Street, City, State, Zip Code)*	

MEDICAL/PARTICIPATORY RELEASE

	Initials
I, being the custodial parent, legal guardian or managing conservator of the applicant indicated on the reverse of this form, do hereby consent to the treatment of my child/ward by any available and qualified medical facility of the United States Government, or any civilian physician, physician assistant or nurse practitioner, or civilian medical facility as may be required, in the event of illness or injury arising from any authorized activity occurring during Military Adventure Camp (MAC), a community event or recreational activity. This consent includes, but is not limited to, any medical, anesthesia or surgical treatment, or hospital services rendered under the general and/or special instructions of the attending physician, physician assistant or nurse practitioner, or other physicians, physician assistants or nurse practitioners assigned to his/her case.	
I, being the custodial parent, legal guardian or managing conservator of the applicant indicated above, do hereby consent to the Commanding General, U.S. Army Cadet Corps, Inc. (USAC), or his authorized representative, to act *in loco parentis* in my absence for those matters relating to my child's/ward's health, welfare and safety, as well as the necessary execution of such release and participatory documents related to training, community and recreational events.	
I hereby give permission to MAC and USAC personnel to administer basic first aid and over-the-counter medication (in proper dosage and frequency), as may be reasonably necessary, to my child/ward. I further give permission to MAC and USAC personnel to administer those prescription medications provided by me, and prescribed by a licensed health care provider. I also give permission to MAC and USAC personnel to administer those medications prescribed by a licensed health care provider incident to treatment received during MAC. I understand MAC and USAC accepts no responsibility for the administration or possible allergic reaction of prescribed and/or over-the-counter medications.	
I agree a photocopy of this agreement shall be as valid as the original.	

INSURANCE DATA

DOES THE ABOVE APPLICANT HAVE ACCIDENT/ HEALTH/DENTAL INSURANCE? *(Photocopy required)* ☐ YES ☐ NO	WHICH PARENT/GUARDIAN HAS PRIMARY COVERAGE?
NAME OF INSURANCE COMPANY	POLICY NUMBER

PARENTAL CERTIFICATION

I certify that the information contained herein is accurate and correct. As a condition of acceptance, I certify that by initialing above, and signing below, I fully understand and agree to the contents of this medical release.

SIGNATURE OF CUSTODIAL PARENT/ LEGAL GUARDIAN	DATE	SIGNATURE OF CUSTODIAL PARENT/ LEGAL GUARDIAN	DATE

NOTARY STATEMENT

STATE OF ___________________________________, COUNTY OF ___________________________________, ss.:

On ________________________________, 20_______, before me ____

personally came ____, to me known, and known to me to be the individual(s) described in and who executed the forgoing Parental/Guardian Agreement and duly acknowledged to me that (he)(she)(they) executed the same.

SIGNATURE OF NOTARY PUBLIC

[SEAL]

My Commission Expires: _____________________________