.CADET/SENIOR APPLICATION FOR TEXAS WING ACTIVITY

I. GENERAL INFORMATION

LAST, FIRST, MI	CAPID	DOB (DA MON YR)	CHARTER	GROUP

GENDER	HOME TELEPHONE	ALTERNATE PHONE	CAP GRADE	GRADE IN SCHOOL

MAILING ADDRESS (NUMBER, STREET, APT)	CITY	STATE	ZIP CODE

E-MAIL ADDRESS	RELIGIOUS PREFERENCE

ACTIVITY APPLYING FOR	T-Shirt Size	STAFF POSITION SOUGHT (OR WRITE 'NONE'')

II. PAST CAP EXPERIENCE

REMARKS: INCLUDE PREVIOUS ACTIVITIES ATTENDED, POSITIONS HELD, SQUADRON POSITIONS, NATIONAL ACTIVITIES, ETC. PLEASE INSURE THAT YOUR REMARKS *DO NOT* CAUSE CREATE AN ADDITIONAL PAGE. THIS FORM *MUST* REMAIN A SINGLE PAGE.

III. MEDIA RELEASE CONSENT

By signing below I hereby give permission for my (or my child's') photographic image to be used in activity public affairs releases including CAP publications and articles as well as local media outlets. By leaving this section blank you are indicating that CAP may not use your cadet's photograph in any CAP or public publication. (Complete if under 18)

TYPED NAME AND GRADE OF APPLICANT	SIGNATURE OF APPLICANT	DATE
TYPED NAME OF PARENT / LEGAL GUARDIAN	SIGNATURE OF PARENT / LEGAL GUARDIAN	DATE

IV. EMERGENCY NOTIFICATION & CONTACT INFORMATION

Note: Please insure that the supplemental medical information forms are completed and turned in. This section is for notification information only and does not contain medical or other confidential items. Please include at least one contact; you may list two contacts.

EMERGENCY CONTACT 1 NAME	RELATIONSHIP	PRIMARY PHONE NUMBER	ALTERNATE PHONE NUMBER
EMERGENCY CONTACT 2 NAME	RELATIONSHIP	PRIMARY PHONE NUMBER	ALTERNATE PHONE NUMBER

V. CONSENT AND CERTIFICATION

TYPED NAME AND GRADE OF APPLICANT	SIGNATURE OF APPLICANT	DATE
TYPED NAME OF PARENT / LEGAL GUARDIAN (IF UNDER 18)	SIGNATURE OF PARENT / LEGAL GUARDIAN (IF UNDER 18)	DATE

Squadron Commanders: please check this box ☐ that you certify that the above Cadet/Senior is determined eligible for the activity applying for and that all information provided on this form has been determined accurate to the best of your ability and is current on safety information IAW CAPR 62-1 and the TXWG Supplement to CAPR 62-1.

TYPED NAME & GRADE OF CC or Designee	SIGNATURE OF CC or Designee	DATE	CHOICE ___ OF

STAFF USE ONLY: Use RED ink. List serious ALLERGIES.

CAP TXWNG CADET ACTIVITY MEDICAL DISCLOSURE FORM

Parent/guardian/senior member must complete this form in its entirety. Check NONE or NO if such is the case. Failure to disclose all medical conditions is cause for possible dismissal from this activity or encampment.
COPIES OF THE CADET'S IMMUNIZATION RECORD AND INSURANCE CARD MUST BE ATTACHED.

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.

Name	Date of Birth	CAP ID #
Phone #s: Day	**Evening**	**Cell**
Primary Care Physician		**Phone Number**

EMERGENCY CONTACT INFORMATION Parent, guardian, or relative to notify in case of emergency				
Name	**Relationship**	**Day Phone/Cell phone**		**Night Phone**
Address (number, street, apt)	**City**		**State**	**Zip Code**
Insurance Company	**ID Number**		**Phone Number**	

1. List ALL prescription, over-the-counter, and herbal medications this cadet takes. Include medication name, dosage, and time to be given. ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER. DO NOT SEND ANY MEDICATIONS IN DAILY PILL PACKS. **If no medication is required, please check** NONE. ☐ NONE

Medication (ex: Concerta 27mg)	**Dosage** (ex: 1 tablet)	**Time(s) given** (ex: every AM)	**Reason for medication** (ex: ADHD)	**Special Handling Instructions**

Permission is granted to administer the above medications to my cadet during the activity.

SIGNATURE____

2. 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. No product endorsement is implied. PARENTS: PLEASE INITIAL ALL THAT APPLY.

______Acetaminophen (Tylenol®) ______Ibuprofen ______Diphenhydramine (Benadryl®)
______Pseudoephedrine ______Antacids ______Cough/cold products
______Midol® ______Pepto-Bismol® ______Anti-diarrheal products
______Calamine lotion® ______Anesthetic throat spray (Chloraseptic®)
______Antibiotic ointments (eg, Triple Ointment®, Neosporin®, Bacitracin®)
______Other____

3. List all medical conditions or recent injuries: ☐ NONE

MEDICAL HISTORY											
Have you had, or currently have, any of the following? (If 'yes', please explain in remarks section with dates and physicians consulted.)											
Y	N	DESCRIPTION	Y	N	DESCRIPTION	Y	N	DESCRIPTION	Y	N	DESCRIPTION
		Frequent headaches			Ear infections			Chronic diseases			Eye trouble (except glasses)
		Dizziness or fainting			Hernias			Menstrual cramps			Chronic injuries
		Unconsciousness			Pos. TB skin test			Known allergies			Stomach trouble
		Asthma			Epilepsy or seizures			Been admitted to a hospital			Drug or alcohol habit
		Hay fever			Kidney stones			Broken bones			Medical treatment in last 5 years
		Diabetes			Motion sickness			Attempt suicide			Other
		Heart trouble			Nervous trouble			H/L Blood pressure			Other
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.											

4. Please list any allergies to medications, food, insect stings, etc: (Be specific) ☐NONE

5. List any dietary restrictions (eg, medical, religious, vegetarian, etc): ☐ NONE

6. Are you now or have you been waived from PT by a doctor?

☐ No ☐Yes (explain) ____

7. Anything else we should know about this cadet?

☐ No ☐ Yes (explain) ____

8. Copies of the cadet's immunization record and insurance card are attached.☐ Yes

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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 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/senior member signature:______________________Date: _____________________