NAVAL JUNIOR RESERVE OFFICERS TRAINING CORPS
(NJROTC)
STANDARD RELEASE FORM

Date: _____

I, _____, being the legal parent/guardian of _____, a member of the Naval Junior Reserve Officers Training Corps, in consideration of the continuance of his/her membership in the Naval Junior Reserve Officers Training Corps and/or his/her acceptance for Naval Junior Reserve Officers Training Corps training, do hereby release from any and all claims, demands, actions, or causes of action, due to death, injury, or illness, the government of the United States and all its officers, representatives, and agents acting officially and also the local, regional, and national Navy Officials of the United States.

I hereby authorize personnel of the Department of Defense, Armed Forces, Public Health Service, or civilian physicians to render such medical and dental care as may be necessary and medically indicated in the case of my son/daughter/ward during his/her period of training, as is deemed necessary by a qualified practitioner.

I understand that care at a military medical facility for non-military dependents will normally be rendered on a temporary (emergency) basis only: if further care is indicated, the patient will be transferred to non-military care as soon as possible. Emergency care provided to cadets who are not military dependents at a military facility may be subjected to reimbursement, and I may be billed for the care provided. For Navy Medical Department facilities, such care is authorized by NAVMEDCOMINST 6320.3B.

My son/daughter/ward has been determined to have the following allergies:
He/she requires medication for the treatment of:

Below are listed other medical conditions which my son/daughter/ward is known to have, which would preclude or limit in any way his/her participation in physical exercise and athletic programs.
His/her physician is:
Name:
Address:
Telephone (include area code):

Initials _____

Medical Insurance Company *
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

Dental Insurance Company*
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

***This insurance is not required. However, the information provided may be required to obtain non-emergency care.**

PRIVACY ACT NOTIFICATION

Under the authority of 5 U.S.C. Sec. 301, the information regarding your child's/ward's health, medical condition and treatment is requested in order to verify any need to administer medication and to enable medical/dental personnel to diagnose and treat any emergency condition which may arise during training. Pursuant to the Privacy Act, 5 U.S.C. Sec. 552, the requested information will not be divulged without your written authorization to anyone other than NJROTC area personnel involved with administration of NJROTC activities and medical/dental personnel requiring the information in order to effectively treat any medical/dental problem which may arise. Disclosure is voluntary: however, failure to provide the requested information will preclude your child's/ward's participation in the training.

Signature of Parent or Guardian:		
Address:		
City:	State:	Zip:
Telephone (include area code):		

NJROTC HEALTH RISK SCREENING QUESTIONNAIRE

Cadet Name:_____(Printed Name)

NJROTC Unit: Admiral Farragut Academy

Date of your most recent pre-participation sports physical examination_____

Part A – TO BE COMPLETED BY THE CADET AND PARENT/GUARDIAN

Directions: Please answer **Yes** or **No** to the following questions: **(Do not leave any questions blank)**

1. Do you have difficulty doing strenuous (great effort) exercise? _____
2. Have you been told **NOT** to participate in long distance runs, such as a 1.5-mile-run? _____
3. Have you been told **NOT** to do curl-ups or push-ups by a physician or other medical professional? _____
4. Do you exercise less than three times per week for at least thirty minutes? _____
5. Have you had any broken bones or a serious accident in the last three months? _____
6. Do you use tobacco of any kind? _____
7. Have you experienced chest, neck, jaw or arm discomfort while doing physical activity? _____
8. Do you have asthma or are you using an inhaler to aid in breathing?_____
9. Do you experience any shortness of breath with relatively low levels of exercise or exertion?_____
10. In the last month have you felt any chest pain at rest? _____
11. Do you have any known cardiac (heart) disease? _____
12. Do you think you are overweight? _____
13. Do you have dizzy/fainting spells, frequent headaches, or frequent back pains? _____
14. Have you ever experienced dehydration after strenuous physical exercise? _____
15. Are you currently under treatment by a physician or other medical practitioner? _____
16. Has your mother or sister died without any explanation or suffered a heart attack before the age of 55? _____
17. Has your father or brother died without any explanation or suffered a heart attack before the age of 45? _____
18. Do you have high blood pressure or are you on blood pressure medication? _____
19. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication? _____
20. Do you have sugar diabetes? _____
21. Have you experienced episodes of rapid beating or fluttering of the heart? _____
22. Do you suffer from lower leg swelling of both legs? _____
23. Do you have difficulty breathing or have sudden breathing problems at night? _____
24. Do you have any personal history of metabolic disease (thyroid, renal, liver)? _____
25. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises? _____
26. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFT? _____
27. Have you ever been diagnosed with Sickle Cell Trait?_____

_____ _____

Cadet Signature Date Parent/Guardian Signature Date

Part B - If any of the answers to the questions above were **YES,** request that the following section be completed and signed by a licensed medical doctor or registered school nurse:

Significant clinical history and/or current medication and treatment regimen of the above cadet: (Use reverse side if necessary)

Recommended/released for participation in strenuous physical activities including the 1.5-mile-run? **YES** **NO**

_____

Signature of Medical Practitioner Date

CNET Form 1533/106 (09-02)

Naval Science Check-in Sheet for all Upper-School Cadets

Please Print **CLEARLY**

Name: _____.
Last First Middle Initial

Gender (circle one): M / F

Race (circle one):
African American
Alaskan Native
Asian American
Caucasian
Hispanic
Native American
Pacific Islander
Other (Specify, if desired): _____

Date of Birth: _____
Month Day Year (i.e. 02/26/1989)

Have you taken any Naval Science classes in the past (circle one) Yes No

if "Yes", which was the last course taken (circle one) NS-1 NS-2 NS-3 NS-4

Home Address: *Street Address:* _____

City: _____ *State:* _____

Zip Code: _____

Country: _____

Home Telephone Number: *Area Code*: (_____) _____

Work Telephone Number: *Area code*: (_____) _____ *EXT:* _____

Grade going into (circle one) 09 10 11 12

Citizenship: _____

Enrollment date: _____ (MMDDYYYY)

Name of Parent(s) or Guardian(s): _____