Attach Photograph

RETURN COMPLETED

APPLICATION BY MAY 1, 2020

Nathan M. Wolfe Law Enforcement Cadet Academy

Sponsored by
The American Legion Department of South Carolina
In cooperation with
Local and State Law Enforcement Agencies

Please return application with ALL fees, health forms, copy of drivers license or drivers permit if available, copy of health insurance card and all three permission forms to:

The American Legion Department of SC
103 LEGION PLAZA ROAD
Columbia, SC 29210 –
information packet can be downloaded at www.scarolinalegion.org

Only completed applications will be accepted

Name: _____
Last First MI

Preferred name (nickname) _____ **Sponsoring Post#: _____**

Address: _____
Street city state zip

Telephone: (_____) _____Cell (____) _____

Email _____

Height: _____Weight: _____ Date of Birth: _____ Age: _____

T-shirt size (based on men's size)

small ____ medium ____ large ____ x-large ____ xx-large ____ xxx-large ____

Mothers Name: _____

Address: _____

Telephone: home _____ work _____ cell _____

Fathers Name: _____

Address: _____

Telephone: Home _____ Work _____ Cell_____

This application will not be accepted without the signature of the Principal, Senior Counselor or Senior School official.

Date application submitted:_____

High school/Homeschool group:_____

Principal, Senior Counselor or Senior School Official
Recommendation:_____

_____

_____

_____

Signature:_____

Name and Title:_____

Address:_____

Phone number:_____

Sponsoring Post Approval: _____ _____
Signature Date

(Post Commander or Adjutant)

Physicals that will not expire until 6/26/20 will be accepted

Cadet Academy Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male ☐ Female ☐

Address _____ Grade completed _____

City _____ State _____ Zip _____ Phone No. _____

Social Security No. (Optional; may be required by medical facilities for treatment) _____

Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. ***IF FAMILY HAS NO MEDICAL INSURANCE, Circle "NONE."***

In case of emergency, notify:

Name _____ Relationship _____

Address _____

Home phone _____ Business phone _____ Cell phone _____

Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____

Food, Plants, or Insect Bites _____

_____

Immunizations:

The following are recommended. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
☐	☐	Tetanus _____
☐	☐	Pertussis _____
☐	☐	Diptheria _____
☐	☐	Measles _____
☐	☐	Mumps _____
☐	☐	Rubella _____
☐	☐	Polio _____
☐	☐	Chicken pox _____
☐	☐	Hepatitis A _____
☐	☐	Hepatitis B _____
☐	☐	Influenza _____
☐	☐	Other (i.e., HIB) _____

☐ Exemption to immunizations claimed.

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____/_____ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____/_____ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ Distribution approved by: _____/_____ Parent signature MD/DO, NP, or PA Signature Temporary Permanent
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Emergency contact No.: _____

Allergies: _____

DOB: _____

Last name: _____

Part B

PHYSICAL EXAMINATION

Heigh_____Weight_____ Blood Pressure_____Pulse_____

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs				**Other**	**Yes**	**No**	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			**Explain**
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			
Tuberculosis (TB) skin test				☐ Negative ☐ Positive			

Allergies (to what agent, type of reaction, treatment): _____

_____

I certify that I have, today, reviewed the health history, examined this person, and approve this individual for participation in:

☐ Hiking and camping ☐ Competitive activities ☐ Backpacking ☐ Swimming/water activities ☐ Climbing/rappelling
☐ Sports ☐ Running ☐ Scuba diving ☐ Exercise ☐ Challenge ("ropes") course
☐ Hot-weather activity ☐ Wilderness/backcountry treks

Specify restrictions (if none, so state) _____

_____

Certified and licensed health-care providers recognized to perform this exam include physicians (MD, DO), nurse practitioners, and physician's assistants.

To Health Care Provider: Restricted approval includes:

- → Uncontrolled heart disease, asthma, or hypertension.
- → Uncontrolled psychiatric disorders.
- → Poorly controlled diabetes.
- → Orthopedic injuries not cleared by a physician.
- → Newly diagnosed seizure events (within 6 months).
- → For scuba, use of medications to control diabetes, asthma, or seizures.

Provider printed name _____

Signature _____

Address _____

City, state, zip _____

Office phone _____

Date _____

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

NATHAN M. WOLFE LAW ENFORCEMENT CADET ACADEMY

PERMISSION TO PARTICIPATE

I DO HEREBY GIVE MY PERMISSION FOR MY SON/DAUGHTER OR LEGAL WARD TO PARTICIPATE IN ALL ACTIVITIES INVOLVED IN THE AMERICAN LEGION NATHAN M. WOLFE LAW ENFORCEMENT CADET ACADEMY TO INCLUDE:

- ASSORTED EXERCISES
- SPORTS ACTIVITIES
- BOATING SAFETY
- DRIVING COURSE
- FIREARMS

AND ANY OTHER ACTIVITIES OF THE PROGRAM, ALL OF WHICH WILL BE SUPERVISED BY CERTIFIED PERSONNEL IN THAT FIELD.

_____

SIGNATURE:_____

CADET: _____

ADDRESS: _____

_____

TELEPHONE: _____ DATE_____

THE AMERICAN LEGION
NATHAN M. WOLFE LAW ENFORCEMENT CADET ACADEMY

RELEASE AND HOLD HARMLESS AGREEMENT

In consideration for being allowed to participate voluntarily in The American Legion Nathan M. Wolfe Law Enforcement Cadet Academy, I hereby release the S. C. Criminal Justice Academy, S. C. Law Enforcement Division, S. C. Department of Natural Resources, S. C. Department of Corrections, S. C. Department of Public Safety, S. C. Highway Patrol**,** Lexington County Sheriff's Department, Lexington Police Department, University of South Carolina Police Department, Lancaster Police Department, Batesburg-Leesville Police Department, Berkeley County Sheriff's Department, North Augusta Department of Public Safety, Cayce Department of Public Safety, South Carolina Law Enforcement Officers Association, South Carolina Sheriff's Association, Lexington County Law Enforcement Officers Association, Lexington County Aging and Recreation Authority, Art Smart Academy of Irmo, American Legion, Department of South Carolina, Federal Bureau of Investigation of South Carolina and the Charleston County Aviation Authority from any and all liabilities or claims arising from my own participation. I agree that I will never prosecute or in any way aid in prosecuting any person or property that may occur from any cause whatsoever as a result of taking part in this activity.

_____ Date_____
Signature of Participant

FOR MINOR CHILD

I, _____, parent/legal guardian of the above said minor child, consent to his or her taking part in this morale support activity. I will abide by the above.

_____ Date_____

NATHAN M. WOLFE LAW ENFORCEMENT CADET ACADEMY

DATE_____
Dear Parent,

On_____the participants from The American Legion Law Cadet Academy will be given an opportunity to take part in shotgun and/or rifle firing with the SC Department of Natural Resources (SCDNR) Hunter Education Section. This exercise will be conducted by law enforcement officers from the Hunter Education Section of the SCDNR. Please sign the permission form below if you wish for your child to participate in this exercise.

HUNTER EDUCATION
LIVE FIRE PERMISSION FORM

I, _____, give permission for
(print)

_____or, if over 18, I agree participate in shotgun
(print)

And/or rifle firing to be conducted at _____as a part of The American Legion Nathan M. Wolfe Law Enforcement Cadet Academy. I understand that this live fire exercise will include the use of shotguns and/or rifles with live ammunition under qualified supervision.

I release the Department Of Natural Resources and its instructors from any liability.

_____
Signed

_____
Date

I _____, do not wish for_____

To participate in the live fire exercise; however, I will allow my child to observe.

_____
Signed Date