WOLF BATTALION
CADET INFORMATION INTAKE FORM

Review page (2) for instructions for form completion. Improper form completion may require this form to be voided and redistributed.

PRIVACY ACT INFORMATION

This form is used to collect standard information regarding each cadet to input in the Cadet Data Management Information Subsystem (CDMIS). Information provided in this form will be utilized as the primary reference for emergency contact information, school level information, uniform & program information, and instructor/guardian communication.

Information collected within this form is compliant to the USG Privacy Act and is not shared or distributed outside of the NJROTC program and required personnel. Additionally, information may be shared to a federal, state, or local agency or organization if required by law, or in an emergency situation in which relevant information must be shared to maintain the safety of student(s).

STUDENT INFORMATION

1. STUDENT ID NUMBER	**2. STUDENT LAST NAME**	**3. STUDENT FIRST NAME**
4. STUDENT MIDDLE NAME	**5. STUDENT GENDER** ☐ Male ☐ Female	**6. STUDENT RACE**
7. STUDENT BIRTH MONTH	**8. STUDENT BIRTH YEAR**	**9. STUDENT AGE** *(in years)*

COMMUNICATION

10. HOME PHONE NUMBER	**11. CELL PHONE NUMBER**	**12. WORK PHONE NUMBER**
13. STUDENT EMAIL ADDRESS	**14. CONTACT EMAIL ADDRESS** *(primary)*	**15. CONTACT EMAIL ADDRESS** *(secondary)*

ADDRESS

16. STREET NAME		**17. APT/SUITE NUMBER**
18. CITY NAME	**19. STATE**	**20. ZIP CODE**

SCHOOL INFORMATION

21. STUDENT GRADE LEVEL ☐ 09 ☐ 10 ☐ 11 ☐ 12	**22. NAVAL SCIENCE LEVEL** ☐ I ☐ II ☐ III ☐ IV	**23. GRADUATION YEAR**

FORM INFORMATION

24. JROTC ENROLLMENT

☐ Yes ☐ No a. I have previously been enrolled in any JROTC program.

☐ Yes ☐ No b. I have previously been enrolled in the SKHS NJROTC program.

☐ Yes ☐ No c. There has been an absence of NJROTC enrollment one semester or longer.

25. ACKNOWLEDGED BY:

a. STUDENT SIGNATURE	**b. DATE SIGNED**
c. PARENT/GUARDIAN SIGNATURE	**d. DATE SIGNED**

INSTRUCTIONS FOR FORM COMPLETION

1. STUDENT ID NUMBER: The identification number assigned to each student by the South Kitsap School District (typically a number starting with “0”).
2. STUDENT LAST NAME: As stated.
3. STUDENT FIRST NAME: As stated.
4. STUDENT MIDDLE NAME: As stated. If student does not have a middle name, write a “-” in the provided space.
5. STUDENT GENDER: The sex of the student participant.
6. STUDENT RACE: As stated.
7. STUDENT BIRTH MONTH: As stated.
8. STUDENT BIRTH YEAR: Full birth year of the student participant.
9. STUDENT AGE: As stated. Include only the year of the student.
10. HOME PHONE NUMBER: Include area code. If no home phone number, write a “-” in the provided space.
11. CELL PHONE NUMBER: Include area code. If no cell phone number, substitute with the best contact number of the student’s primary guardian.
12. WORK PHONE NUMBER: Include area code. If no work phone number, substitute with a contact number of a student’s guardian.
13. STUDENT EMAIL ADDRESS: Student’s email address provided by the South Kitsap School District.
14. PRIMARY CONTACT EMAIL ADDRESS: Primary email address to contact a student’s parent(s)/guardian(s).
15. SECONDARY CONTACT EMAIL ADDRESS: Secondary email address to contact a student’s parent(s)/guardian(s).
16. STREET NAME: Street name of the student’s primary residence.
17. APT/SUITE NUMBER: Apt/Suite Number of the student’s primary residence. If not applicable, write a “-” in the provided space.
18. CITY NAME: City name associated with the provided street name (form item 16).
19. STATE: State name associated with the provided street name (form item 16).
20. ZIP CODE: Zip Code associated with the provided street name (form item 16).
21. STUDENT GRADE LEVEL: The current grade level of the student participant. If form is completed during the summer, select the grade level the student is going into.
22. NAVAL SCIENCE LEVEL: The current Naval Science level of the student participant. If form is completed during the summer, select the Naval Science level the student is going into. Freshmen are always Naval Science level I.
23. GRADUATION YEAR: Graduation year of the student participant from South Kitsap High School.
24. JROTC ENROLLMENT: Information regarding the enrollment background of the cadet.
25. ACKNOWLEDGED BY:
    a. STUDENT SIGNATURE: Signature from the cadet acknowledging all form information as accurate and complete to the best of their ability.
    b. DATE SIGNED: The full date (Month/Day/Year) in which form item 25a was completed.
    c. PARENT/GUARDIAN SIGNATURE: Signature from the cadet acknowledging all form information as accurate and complete to the best of their ability.
    d. DATE SIGNED: The full date (Month/Day/Year) in which form item 25c was completed.

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

NJROTC HEALTH RISK SCREENING QUESTIONNAIRE

Cadet Name: _____(Printed Name)

NJROTC Unit: _____High School

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?	☐ **Yes** ☐ **No**
2.	Have you been told **NOT** to participate in long distance runs, such as a 1-mile-run?	☐ **Yes** ☐ **No**
3.	Have you been told **NOT** to do curl-ups or push-ups by a physician or other medical professional?	☐ **Yes** ☐ **No**
4.	Do you exercise less than three times per week for at least thirty minutes?	☐ **Yes** ☐ **No**
5.	Have you had any broken bones or a serious accident in the last three months?	☐ **Yes** ☐ **No**
6.	Do you use tobacco of any kind?	☐ **Yes** ☐ **No**
7.	Have you experienced chest, neck, jaw or arm discomfort while doing physical activity?	☐ **Yes** ☐ **No**
8.	Do you have asthma or are you using an inhaler to aid in breathing?	☐ **Yes** ☐ **No**
9.	Do you experience any shortness of breath with relatively low levels of exercise or exertion?	☐ **Yes** ☐ **No**
10.	In the last month have you felt any chest pain at rest?	☐ **Yes** ☐ **No**
11.	Do you have any known cardiac (heart) disease?	☐ **Yes** ☐ **No**
12.	Do you think you are overweight?	☐ **Yes** ☐ **No**
13.	Do you have dizzy/fainting spells, frequent headaches, or frequent back pains?	☐ **Yes** ☐ **No**
14.	Have you ever experienced dehydration after strenuous physical exercise?	☐ **Yes** ☐ **No**
15.	Are you currently under treatment by a physician or other medical practitioner?	☐ **Yes** ☐ **No**
16.	Has your mother or sister died without any explanation or suffered a heart attack before the age of 55?	☐ **Yes** ☐ **No**
17.	Has your father or brother died without any explanation or suffered a heart attack before the age of 45?	☐ **Yes** ☐ **No**
18.	Do you have high blood pressure or are you on blood pressure medication?	☐ **Yes** ☐ **No**
19.	Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication?	☐ **Yes** ☐ **No**
20.	Do you have sugar diabetes?	☐ **Yes** ☐ **No**
21.	Have you experienced episodes of rapid beating or fluttering of the heart?	☐ **Yes** ☐ **No**
22.	Do you suffer from lower leg swelling of both legs?	☐ **Yes** ☐ **No**
23.	Do you have difficulty breathing or have sudden breathing problems at night?	☐ **Yes** ☐ **No**
24.	Do you have any personal history of metabolic disease (thyroid, renal, liver)?	☐ **Yes** ☐ **No**
25.	Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises?	☐ **Yes** ☐ **No**
26.	Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFT?	☐ **Yes** ☐ **No**
27.	Have you ever been diagnosed with Sickle Cell Trait?	☐ **Yes** ☐ **No**
28.	Do you have a current prescription for epinephrine (or “epi” pen) for situational use?	☐ **Yes** ☐ **No**

If you answered yes to any question please continue to the second page.

Cadet Signature Date Parent/Guardian Signature Date

Cadet Name:

Part B – TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER

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 below as neccessary)

Recommended/released for participation in strenuous physical activities including the 1.0-mile-run? ☐ **Yes** ☐ **No**

Signature of Medical Practitioner Date

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):		