Joliet Police Explorers
Post #220

Instructions: Fill out this application completely and accurately. If you fill out this application properly it will help to process your application in a timely manner. All statements are subject to verification. If there is inadequate writing space that is provided, then place the number to the question and the appropriate answer on the continuation sheet that is provided. Use the sign N/A (Not Applicable) if the question does not apply.

Date of Interview: ____________
Date of Membership: ___________

1. Name: ____
   Last First Middle
2. Address: ____
   Street City State Zip
3. Soc. Sec. Number: _____-_____-______ 4. Home Tel. # ____________
5. Date of Birth: __________________ 6. Sex: Male ____ Female ___
7. Place of Birth (City, State): ______________________ 8. Height _______
9. Weight _____lbs. 10. Age _____yrs. old 11. Eye Color __________
12. Hair Color ________ 13. List name you want to be called: _______________
14. List any scars, birthmarks, or tattoos: __________________________________
15. Are you a U.S Citizen: Yes _____ No ____
16. List your parents names: Father ________________________
    Mother ________________________
    Siblings ________________________
    ____
    ____
17. Do you have a Valid Drivers License? Yes _____ No _______
18. DL# ________________Date of Expiration _______________
19. Do you have any health problems? Yes ______ No __________ If "Yes" list
____

20. List the various schools you have attended: (Give name, city, and state)
    Grammar School - ______________________________ Graduate Yes__ No ____
    ______________________________ Graduate Yes__ No ____
    ______________________________ Graduate Yes__ No ____
    High School - ______________________________ Graduate Yes__ No ___
    ______________________________ Graduate Yes__ No ___

21. List any Colleges you have attended and your major: (Give name, city, and state)
    College ______________________________ Graduate Yes__ No__
    ______________________________ Graduate Yes__ No__

22. List all social and academic clubs:
    ____
    ____
    ____

23. List all extra curricular activities: ______________________________
    ____
    ____

24. Have you ever been arrested? Yes ____ No ____
    If "Yes" give details ______________________________
    ____

25. Do you use narcotics or barbiturates? Yes ____ No ____ If "Yes" give details
    ____

26. Do you use alcohol habitually? Yes ___ No ____ If "Yes" give details __________
    ____

27. Have you ever been reported missing or a runaway? Yes ___ No ____
    If "Yes" give details ______________________________

28. Have you ever been on probation? Yes ___ No ___ If "Yes" give details
    ____

29. Have you ever been a gangmember? Yes ___ No ___
    List Name of Gang and your nickname ______________________________

30. List all traffic tickets in the last 3 years:(Date and nature of violation)
    ____
    ____
    ____

31. Have you ever been fingerprinted? Yes ____ No ____

32. Has any member of your immediate family been arrested? Yes ____ No ____

33. Are there any court cases pending against you? Yes ____ No ____

34. List all jobs you have held for the last 3 years (List present job first)

Company Name   City/State   How long employed?   Reason for leaving?

____

____

____

____

35. Were you ever fired? Yes ___ No ____

36. List the names of two adults that are not related to you or past employers that have known you for at least one year. (Include name, address, city, state, telephone # and how long they have known you)

____

____

37. List person to be notified in case of emergency:

Name   Address   Home Phone   Work PhoneRelationship

____

Continuation Space:

____

____

____

____

____

____

____

I HEREBY STATE THAT THERE ARE NO OMISSIONS, WILLFUL MISREPRESENTATIONS, OR FALSIFICATIONS IN THIS QUESTIONNAIRE, AND ALL MY ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

______________________________   DATE ____________________

Full Signature

PERSONAL HEALTH AND MEDICAL RECORD
PART 1 AND PART 2

Part 1 (update annually for all participants). Activity: Camping, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

Part 2 (required once every 36 months for all participants under 40 years of age). Activity: Camping or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

Note: Some states require an annual medical evaluation. Your Learning for Life representative can advise you about the requirements for your state.

If your child has had a medical evaluation **(physical examination)** within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Part 2 section of this form) must be scheduled by a *licensed health-care practitioner. This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for Learning for Life purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

THIS FORM IS NOT TO BE USED BY ADULTS OVER 40.

PART 1 PERSONAL HEALTH AND MEDICAL HISTORY
(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name______________________________ Date of birth__________ Age_____ Sex_____

Name of parent or guardian______________________________ Telephone__________

Home address__________________ City______________ State________ Zip__________

Business address__________________ City______________ State________ Zip__________

If person named above is not available in the event of an emergency, notify

Name__________________ Relationship______________ Telephone__________

Name__________________ Relationship______________ Telephone__________

Name of personal physician______________________________ Telephone__________

Personal health/accident insurance carrier______________________________ Policy No.__________

I give permission for full participation in Learning for Life programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date__________ Signature of parent/guardian or adult______________________________

Some hospitals require the parent/guardian signature to be notarized.

NAME__________ UNIT__________ CAMPSITE__________

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☐ Explain: ____________

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐

Explain: ____________

List any medications to be taken at camp: ____________

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: ____________

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: ____________

Immunizations: (Give date of last inoculation.)

Tetanus toxoid	______	Measles	______	Polio	______
Diphtheria	______	Mumps	______		______
Pertussis	______	Rubella	______		______

PART 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name ____________ Age ______

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height ______ Weight ______ BP ____/____ Pulse ______

Lab: Urinalysis (dipstick) ______ Albumin ______ Sugar ______

VISION: Normal ______ Glasses ______ Contacts ______

HEARING: Normal ______ Abnormal ______ Explain ______

Check box:	N	Abn		N	Abn		N	Abn
Growth development	☐	☐	Teeth	☐	☐	Genitalia	☐	☐
Skin	☐	☐	Cardiopulmonary system	☐	☐	Musculoskeletal	☐	☐
HEENT	☐	☐	Hernia	☐	☐	Neurobehavioral	☐	☐

Explain: ____________

Limitations

Activity restrictions ____________

Diet restrictions ____________

Signature ____________ Date ______
Licensed health-care practitioner*

Address ____________ Phone ______

City, State, Zip ____________

***Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for Learning for Life purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.**

INTERVAL RECORD	SCREENING EXAMINATION	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By

PHOTOCOPING THIS FORM IS PERMITTED.

NAME ______ TROOP ______ CAMPSITE ______

PLEASE TYPE OR PRINT.

NAME ____________ UNIT ____________

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

PERSONAL HEALTH AND MEDICAL RECORD FORM—Part 3

LEARNING FOR LIFE

All Part 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees.

I. IDENTIFICATION

Age____ Sex____ Date of Birth* Mo. Day Year

Name ______________________ (Last name / First name / Initial)

Address ______________________

City & State ______________________ Zip ________

Health/Accident insurance ______________ Policy no. ________

IN AN EMERGENCY NOTIFY:

Name ______________________ Relationship ________

Address ______________________ Home phone

City & State ______________________ Business phone

Personal Physician ______________________ Phone

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

☐ Allergy to a medicine, food, plant, animal, or insect toxin

☐ Any condition that may require special care, medication, or diet

☐ ADHD (Attention Deficit Hyperactive Disorder)

☐ Asthma ☐ Convulsions ☐ Heart trouble ☐ Contact lenses

☐ Diabetes ☐ Fainting spells ☐ Bleeding disorders ☐ Dentures

EXPLAIN ______________________

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? ☐ No ☐ Yes Does applicant take medicine regularly or have special care? ☐ No ☐ Yes If yes, explain.

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in Learning for Life programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian ______________________ (Must sign if applicant is 18 or younger)

Applicant's signature ______________________

Date signed ______________________

IV. IMMUNIZATIONS

If disease, put "D" and year.

	Last year given
Tetanus	
Diphtheria	
Pertussis	
Measles	
Mumps	
Rubella	
Polio	
Chicken Pox	

Religious preference

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in:

☐ Hiking and camping ☐ Water activities

☐ Competitive sports ☐ All activities

Specify exceptions ______________________

Recommendations (explain any restrictions OR limitations): ______________________

Date ________

Signed ______________________ *Licensed health-care practitioner

*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for Learning for Life purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI *before seeing a licensed health-care practitioner*. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

- Date of most recent complete physical examination (month and year) ______________ 20____
- Are you aware of any current health problems? ☐ No ☐ Yes
- Now under medical care or taking medicines? ☐ No ☐ Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? ☐ No ☐ Yes

Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):	No	Yes	Year	Details/Medicines
Serious illness	☐	☐		
Serious injury	☐	☐		
Deformity	☐	☐		
Surgery	☐	☐		
Skin, glands	☐	☐		
Ears, eyes	☐	☐		
Nose, sinus	☐	☐		
Teeth, tonsils	☐	☐		
Dentures	☐	☐		
Bridge	☐	☐		
Chest, lungs	☐	☐		
Heart	☐	☐		
Murmur	☐	☐		
Rheumatic fever	☐	☐		
Stomach, bowels	☐	☐		
Appendicitis	☐	☐		
Kidneys or urine	☐	☐		
Albumin	☐	☐		
Sugar	☐	☐		
Infection	☐	☐		
Bed-wetting	☐	☐		
Menstrual problems	☐	☐		
Hernia (rupture)	☐	☐		
Back, limbs, joints	☐	☐		
Sleepwalking	☐	☐		
Nervous condition	☐	☐		
Other (explain)	☐	☐		

VII. HEALTH EXAMINATION

Licensed Health-Care Practitioner:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

Date ______________ VISION: Normal ________ HEARING: Normal ________

Ht. ________ Wt. ________ Glasses ________ Abnormal ________

B.P. ______ / ______ Pulse ______ Contacts ________

Check box if normal; circle if abnormal and give details below:

☐ Growth, development ☐ Teeth, tonsils ☐ Genitourinary

☐ Skin, glands, hair ☐ Respiratory ☐ Skeletomuscular

☐ Head, neck, thyroid ☐ Cardiovascular ☐ Neuropsychiatric

☐ Eyes, ears, nose ☐ Abdomen, hernia, rings ☐ Other (specify)

COMMENTS ______________________

LABORATORY: Urinalysis (Dip stick) Albumin ________ Sugar ________

REVIEW FOR CAMP OR SPECIAL ACTIVITY						
DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD (CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.)		
DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.	BY: