

JCLC IN/OUT PROCESSING

Last name, First, MI: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip Code: _____

School: _____ Let Level: _____

DOB: _____

Unit of Assignment:

Company: _____ Platoon: _____ Squad: _____

Cadre Institutional Representative: _____

Person to be notified in case of emergency:

Name and relationship: _____

Address: _____ City: _____

State: _____ Zip Code: _____

School: _____ Let Level: _____

Date In-processed: _____

Date Out-processed: _____

Covenant Not to Sue for JCLC on File: _____

Special Power of Attorney on File (as needed): _____

CADET INFORMATION

STATEMENT REQUIRED BY PRIVACY ACT OF 1974

1. **AUTHORITY:** Title 10, U.S. Code 2102
 2. **PRINCIPAL PURPOSE(S):** To gather information, emergency points of contact, and statement of the physical condition of JROTC Cadets attending JCLC.
 3. **ROUTINE USES:** Normal Personnel Actions—Disclosures of information may be provided to proper authorities in actions regarding medical treatment, legal actions, investigation of accidents, and preparation of statistics and training records resulting from JCLC.
 4. **MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION:** Disclosure is voluntary. Failure of Cadet to complete form will disqualify JROTC Cadet from participating in JCLC.
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1. **Cadet:** _____
(Rank, Last Name, First, MI)
 2. _____
(SSN) (Name of School)
 3. I will attend JCLC during () First Cycle or () Second cycle
 4. **Parent or Guardian** _____
(Name and Address)
 5. Telephone: _____ Other: _____
 6. **Family Doctor:** _____
(Name and Address)
 7. Telephone: _____ Other: _____
 8. **Dentist:** _____
(Name and Address)
 9. Telephone: _____ Other: _____
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NOTE: IF PARENT OR GUARDIAN CANNOT BE CONTACTED, PLEASE LIST ONE OTHER PERSON TO CONTACT IN CASE OF AN EMERGENCY.

10. **Emergency Contact:** _____

(Name and Address)

11. Telephone: _____ Other: _____

STATE OF PHYSICAL CONDITION

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Initials

To the best of my knowledge, my son/daughter/ward is in good physical condition. Participation in JCLC, in my opinion, will not have an adverse effect on his/her health and well-being. I will inform the JCLC Commander of any changes.

()
Initials

My son/daughter/ward has a history of (identify illnesses; Heart disease, Asthma, Overweight, Sinus, Rheumatic Fever, Ear Infection, Headaches, or any other ailments) _____

and is on _____ medication. He/she is allergic to the

following medication: _____

NOTE: Students that are found to have previous history of any type illness, past injury, and/or symptoms of suspected medical ailment, will be returned home if treatment is needed or desired.

DENTAL RECORDS

I acknowledge my dental records contain detail profiles and/or x-rays of sufficient detail for identification.

I (do) (do not) have a dentist or dental records.

(Signature of Cadet/Parent/Guardian)

(Signature of Cadet/Parent/Guardian)

CONSENT TO MEDICAL TREATMENT

STATEMENT REQUIRED BY PRIVACY ACT OF 1974

(1) AUTHORITY: TITLE 10, U.S. CODE 2102.

(2) PRINCIPAL PURPOSES: A statement authorizing medical care in civilian or government medical facilities while attending or traveling to or from JCLC.

(3) ROUTINE USES: Normal personnel actions: Disclosure of information may be provided to proper authorities in actions regarding medical treatment, legal actions as a result of injury or death, and investigation of accident resulting from JCLC.

(4) MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION: Voluntary. Failure to complete form will disqualify JROTC Cadet from participating in specific voluntary training exercises.

I _____, consent to be treated in an Army Hospital, or any other government or civilian medical facility, near or en-route to _____,
(Installation, State)

while attending or traveling to or from JCLC from _____,
(MM/YY)

This consent encompasses all procedures and treatments as are found to be necessary or desirable, in the judgment of the professional staff of any of the above-named medical facilities. I understand that this consent is of a general nature and accordingly list the following exceptions to this consent (if no exceptions write "No Exceptions")

I (am) (am not) on medication. (List type, if on medication)

I (am) (am not) allergic to medication. (List type, if allergic)

It is understood that this consent can be withdrawn in writing or orally at anytime.

Signature of Witness

Signature of Cadet

Print Name of Witness

Print Name of Cadet SSN _____

PARENT OR GUARDIAN: (When Cadet is a minor or unable to give consent), I _____, parent/guardian of _____ have read and understood the above consent to treatment and hereby expressly consent to the above-described treatment.

Signature of Witness

Signature of Parent

Print Name of Witness

Print Name of Parent SSN _____