

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION MEDICAL HISTORY SUPPLEMENTAL	<i>FOR OFFICIAL USE ONLY</i>
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NOTICE

This form, used as a supplement to the Report of Medical History, is **MANDATORY** for all Cadets who are currently taking medication and will report to training with prescription and/or non-prescription (over the counter) medications. Cadets may bring prescription and non-prescription medication to training as long as the medication is not for a contagious illness or physical condition that would normally preclude his/her full participation in rigorous physical activity. Medication must NOT have expired. This form is to be used in conjunction with the current report of Medical History when screening cadets prior to attending "ALL" trainings for those taking medications.

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. If the cadet is taking prescription medications, a qualified medical provider must endorse this document in Section 10, confirming the accuracy of the prescription information provided. Medical provider signature for OTC medications is NOT REQUIRED; parent signature is sufficient for OTC medications.

Commanding Officers of Training Contingents (COTC) and Senior Escort Officers (SEO) retain the obligation and right to deny acceptance for training to any Cadet if upon review of the Report of Medical History and this document, it is determined that the Cadet is not physically and/or medically qualified (without ADA accommodation). This includes a determination that they do not have sufficient or qualified personnel to administer required medications. Parents/Legal Guardians should be consulted before making these type determinations.

1. PERSONNEL INFORMATION

1a. Last Name	1b. First Name	1c. MI	1d. Social Security Number
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2. TRAINING INFORMATION

2a. Training Code	2b. Training Start Date	2c. Training End Date	2d. Training Days	2e. Training Location
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3. PACKAGING AND LABELING REQUIREMENTS

3a. Prescription Medication <ul style="list-style-type: none"> Must be in the original container from the pharmacy or manufacturer. Must have a complete prescription label attached to the container. The container will only contain the medication it is labeled for. The Cadet must be the person prescribed the medication and his or her name must appear on the prescription label. 	3b. Non-Prescription Medication (Over the Counter) <ul style="list-style-type: none"> Must be in the original container from the manufacturer. Must have a complete manufacturer's label attached to the container identifying the contents and directions for use. The container will only contain the medication it is labeled for.
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4. PRESCRIPTION OR NON-PRESCRIPTION MEDICATION *(Use additional documents if more than three medications are provided)*

4a. Name of Medication	4b. Strength	4c. Total Quantity Required	4d. Total Quantity Sent
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4e. Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	4f. Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 4l and/or Block 7
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4g. Prescribing Provider Name	4h. Prescribing Provider Phone Number	4i. Prescribing Provider Phone Number (alternate)
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4j. Reason for medication *(Describe in detail if necessary)*

4k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

4l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.

4m. Expected effects if medication is not taken as directed.

5. PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS *(Use additional documents if more than three medications are provided)*

5a. Name of Medication	5b. Strength	5c. Total Quantity Required	5d. Total Quantity Sent
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5e. Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	5f. Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 5l and/or Block 7
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5g. Prescribing Provider Name	5h. Prescribing Provider Phone Number	5i. Prescribing Provider Phone Number (alternate)
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5j. Reason for medication *(Describe in detail if necessary)*

5k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

5l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.

5m. Expected effects if medication is not taken as directed.

MEDICAL HISTORY SUPPLEMENTAL			
6. PRESCRIPTION OR NON-PRESCRIPTION MEDICATION <i>(Use additional documents if more than three medications are provided)</i>			
6a. Name of Medication	6b. Strength	6c. Total Quantity Required	6d. Total Quantity Required
6e. Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:		6f. Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 6i and/or Block 7	
6g. Prescribing Provider Name	6h. Prescribing Provider Phone Number	6i. Prescribing Provider Phone Number (alternate)	
6j. Reason for medication <i>(Describe in detail if necessary)</i>			
6k. Relevant side effects to be observed if any: <i>(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)</i>			
6l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
6m. Expected effects if medication is not taken as directed			
7. REMARKS (please include comments as required by Blocks 4, 5 and/or 6. Also provide any other medical history that you or your physician deems important)			
8. STATEMENT OF UNDERSTANDING AND CONSENT			Parent/Guardian Initial Below
8a. During the NSCC/NLCC training evolution, NSCC medical personnel on duty and/or assigned NSCC staff members have my permission to administer the medication listed in Block 4, Block 5 and/or Block 6. I understand that all medications provided to the NSCC training contingent staff, must be in the original medication bottle containing all of the information required by Block 4, 5, and/or 6.			
8b. I give consent to the NSCC staff to contact the medical provider as needed for clarification with regard to medications listed and the conditions for which the medication is prescribed. The medical provider has been notified that the NSCC is authorized to obtain medical/prescription information if necessary.			
8c. I understand that all medications will be collected at the beginning of training and administered to the Cadet based on dosing instructions on the medication bottle/package. In no instance will Cadets be allowed to self-medicate with any medication whether it is over the counter or prescription. I understand I must provide the required amount of medication needed for the entire duration of the training evolution.			
8d. I understand that the Commanding Officer of the Training Contingent (COTC), and/or National Headquarters (NHQ) retains the authority to not accept and/or terminate Cadet's training at any time due to medical/other reasons. If terminated, parent agrees to immediately pick up their son/daughter upon notification by the COTC and/or training staff.			
9. AUTHORIZATION AND RELEASE			
I certify that, to the best of my knowledge, the information provided is true and accurate and I have disclosed all pertinent medical history. Furthermore, I authorize the Naval Sea Cadet Corps, its agents, officials, and training staff members, to dispense medication listed on this authorization and I "Hold Harmless" the Naval Sea Cadet Corps from any and all liability, actions, or causes of action for damages or injury that may arise, directly or indirectly, from my child's use of medication while participating in Naval Sea Cadet Corps activities. I understand that training staff members may not be medical professionals and that medication will be dispensed according to the manufacturer's instructions and/or the instructions I provided on this authorization.			
9a. Name of Parent/Guardian (Type or Print)	9b. Signature		9c. Date (DD MMM YY)
10. ENDORSEMENTS			
I have reviewed the medical record of this cadet and certify that the medications listed on this form are true and correct as prescribed and that this cadet is physically able to attend the listed training evolution.			
10a. Name of Medical Provider (Type or Print)	10b. Signature		10c. Date (DD MMM YY)
I certify that I have reviewed the above information and the Cadet listed on this form is physically able to attend the listed training evolution.			
10d. Name of Commanding Officer (Type or Print)	10e. Signature		10f. Date (DD MMM YY)