U.S. NAVAL SEA CADET CORPS
U.S. NAVY LEAGUE CADET CORPS

CADET APPLICATION
MEDICAL HISTORY SUPPLEMENTAL

FOR OFFICIAL USE ONLY

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.** USNSCC ID Number

2. TRAINING INFORMATION

2a. Training Code	**2b.** Training Start Date	**2c.** Training End Date	**2d.** Training Days	**2d.** Training Location
			0	

3. PACKAGING AND LABELING REQUIREMENTS

3a. Prescription Medication
- 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)
- 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.

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

4e. Storage (Use Block 7, if necessary)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:

4f. Frequency and Dosage (check one)
☐ As needed, as labeled ☐ On schedule, as labeled ☐ Other: See Block 4l and/or Block 7

4g. Prescribing Provider Name	**4h.** Prescribing Provider Phone Number	**4i.** Prescribing Provider Phone Number (alternate)

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

5e. Storage (Use Block 7, if necessary)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:

5f. Frequency and Dosage (check one)
☐ As needed, as labeled ☐ On schedule, as labeled ☐ Other: See Block 5l and/or Block 7

5g. Prescribing Provider Name	**5h.** Prescribing Provider Phone Number	**5i.** Prescribing Provider Phone Number (alternate)

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 activates or location.

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

MEDICAL HISTORY SUPPLEMENTAL

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

6a. Name of Medication	**6b.** Strength	**6c.** Total Quantity Required	**6d.** Total Quantity Required

6e. Storage (Use Block 7, if necessary)	**6f.** Frequency and Dosage (check one)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:	☐ As needed, as labeled ☐ On schedule, as labeled ☐ Other: See Block 6l and/or Block 7

6g. Prescribing Provider Name	**6h.** Prescribing Provider Phone Number	**6i.** Prescribing Provider Phone Number (alternate)

6j. Reason for medication *(Describe in detail if necessary)*

6k. 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.)*

6l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activates 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)