New York Wing Encampment Online Application Part II

NAME (Last Name, First Name, Middle Initial)	CAPID

You are welcome to send a check for the registration fee with this application, or you can pay by credit card in the National Website Registration Zone. If you are applying for financial aid from National Civil Air Patrol (CEAP), please do no sent any payment now - if you do not receive CEAP, you will be billed when accepted.

Social Security Number:
(Required for Military Flight)

Religious Preference:

T-Shirt Size (Adult Sizing): **XS** ☐ **S** ☐ **M** ☐ **L** ☐ **XL** ☐ **2XL** ☐ **3XL** ☐ **4XL** ☐

PT Short Size (Cadets Only): **NONE.** ☐ **XXS** ☐ **XS** ☐ **S** ☐ **M** ☐ **L** ☐ **XL** ☐ **2XL** ☐ **3XL** ☐ **4XL** ☐

– Seniors should select NONE - if wish to purchase shorts, indicate size and will be charged $10.

Any Special Food Needs:

Emergency Contact **PH#**

Sending this form assumes that you have registered for the encampment on eServices. If you have not done so, please register before sending. If you are unable to register, please contact the encampment Registrar.

All parts of this form must be received by the appropriate deadline date listed on the encampment website (nyw.cap.gov/encampment). Your application will not be considered if anything is missing. This document can be mailed or scanned and uploaded on the website. (Login to the secura area of the website.).

Do not take pictures of application with phone, must be in pdf format.!

REGISTRAR:

1st Lt Kimberly Dabrowski
554 Sandy Plains Road
Leeds NY 12451

encampment.registrar@nyw.cap.gov
(785) 249-4886

APPLICATION FOR CAP ENCAMPMENT OR SPECIAL ACTIVITY				
This application is used for Wing Encampments and National Cadet Special Activities (NCSA/CSA) only. Local versions may be used. For all other activities, use CAPF 60-80.				
Name (Last, First, Middle Initial)		**CAPID**	**CAP Grade**	**Gender**
Member Type	**Charter No. (e.g. GLR-MI-059)**	**Date of Birth**	**Shirt Size**	
Address (Include No., Street, City, State and Zip Code)		**Height (inches)**	**Weight (lbs)**	
		E-Mail Address		
Home Phone Number	**Cell Phone Number**	**Parent or Guardian E-Mail Address**		
Title of Activity	**Location of Activity**		**Activity Dates**	
Staff Position(s) Sought **Enter Staff Application on nyw.cap.gov/encampment**				

Applicant Signature

I hereby submit my application and ask to be considered for the above activity. I certify that the above information is correct and that all requirements for attendance will be completed by the required date.

Date ____________ Signature of Applicant ____________

Release by Parent or Guardian

Not required for cadets who have reached the age of majority.

For special activities using eServices registration, parent signature obtained after cadet is offered a slot at activity.

WHEREBY my child has applied for the activity or encampment referred to above, In consideration of the permission extended to my child by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity/encampment or activities/encampments, I do hereby for myself, my heirs, executors, and administrators release and forever discharge the Civil Air Patrol, Inc./United States of America, and all its officers, agents and employees acting official or otherwise, from any and all claims, demands, actions or causes of action, on account of the death or on account of any injury to my child which may occur during said activity/encampment or activities/encampments or continuances thereof, as well as all ground and flight operations incident thereto. In addition, by my signature below, I certify the applicant is my minor child or ward and they will follow all rules, regulations, and directives as established by the Civil Air Patrol, Inc., activity project officer or encampment commander, or other staff members. If my child does not follow the above-mentioned rules, regulations, and directives he/she may be sent home at the discretion of the project officer, encampment commander or activity directory at my expense.

However, in case of injury, disease or other illness, permission is hereby granted to treat the applicant as required, and if the applicant is released from the activity before recovery from said injury, disease, or illness, further treatment will be provided by myself.

Date ____________ Parent or Legal Guardian Signature ____________

Squadron Certification

I hereby endorse this application and will support the cadet's participation if selected. I certify that the above information is correct and that all requirements for attendance will be completed by the required dates.

Squadron Cmdr Signature not needed - approved in eServices

Date ____________ Squadron Commander ____________

CAP MEMBER HEALTH HISTORY FORM

This information is CONFIDENTIAL and for official use only. It cannot be released to unauthorized persons. Answer all questions as accurately as possible so that the activity or encampment staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you. This form will also provide medical information in a case when you are unable to do so.

Name *(Last, First, Middle)*			**Grade**	**CAPID**	**Charter Number**
Date of Birth	**Height**	**Weight**	**Hair Color**	**Eye Color**	**Gender**

Allergies: List Names of Medication or Other Allergies *(i.e., bee sting, food, plants)* and types of reactions; please note food allergy details with dietary restrictions below on back as well.

Do You Now Have Or Have You Ever Had Any Of The Following? *Explain any yes' in the remarks section below or attach additional sheet. Conditions not specifically noted below having the potential to interfere with performance during the special activity or encampment should be documented in the remarks section.)*

If "Yes" is marked in an item with multiple choices, please circle which problem applies.

No	Yes		No	Yes	
☐	☐	Decreased vision, glaucoma, contacts	☐	☐	Chronic or recurring injuries
☐	☐	Ear infections, perforation	☐	☐	Activity, mobility restrictions
☐	☐	Difficulty equalizing ears	☐	☐	Use of cane, walker, wheelchair
☐	☐	Hearing loss, hearing aid	☐	☐	Back or neck pain or injury
☐	☐	Allergies, nasal stuffiness	☐	☐	Migraine or severe headaches
☐	☐	Anaphylaxis, serious allergic reaction	☐	☐	Dizziness or fainting spells
☐	☐	Asthma, emphysema (COPD)	☐	☐	Head injury, unconsciousness
☐	☐	Ever use an inhaler	☐	☐	Epilepsy or seizure
☐	☐	Short of Breath with activity	☐	☐	Stroke, paralysis
☐	☐	Heart Attack, chest pain, angina	☐	☐	Thyroid problems (low or high)
☐	☐	Heart murmur, heart problems	☐	☐	Diabetes, high or low blood sugars
☐	☐	Congestive heart failure	☐	☐	Cancer, leukemia
☐	☐	Irregular or rapid heartbeat	☐	☐	Blood disease, hemophilia
☐	☐	High or low blood pressure	☐	☐	Motion sickness
☐	☐	Stomach trouble, ulcers	☐	☐	Special diet, food allergies
☐	☐	Hepatitis or liver problems	☐	☐	Current bedwetting problems
☐	☐	Diarrhea, constipation	☐	☐	ADD (Attention Deficit Disorder)
☐	☐	Hernia or rupture	☐	☐	Mental illness (bipolar, other)
☐	☐	Kidney disease or stones	☐	☐	Depression, anxiety, suicidal
☐	☐	Prostate problems (men)	☐	☐	Admission to the hospital
☐	☐	Frequent urination	☐	☐	Other chronic medical illnesses
☐	☐	Menstrual cramps (women)	☐	☐	Sleep disorder, sleep apnea
☐	☐	Broken bone, joint problems	☐	☐	Serious Injury

Dietary Restrictions or Limitations *(List any dietary restrictions like food allergies, diabetes, gluten-free, vegetarian diets, etc.)*

Past Surgical History *(List all surgeries including tonsils, ear tubes, appendix, gall bladder, hernia, hysterectomy, heart, heart catheterization, bone and joint and all other surgeries.)*

Date Tetanus Booster ☐ No Td or Tdap Date:	Hepatitis Vaccine ☐ No Date:	Pneumonia Vaccine ☐ No Date:	Varicella Immunization/chickenpox ☐ No Date:	Influenza Vaccine ☐ No Date:

Medication Information - *Include supplements, over-the-counter medicines, herbals, creams, etc., or write "None".*

Name of Medication/Inhaler	Tablet Strength	Times taken per day	Reason for Medication	Any Special Dosing or Storage Instructions (i.e., as needed, with meals, must be refrigerated, etc.)
1.				
2.				
3.				
4.				

Social History

Tobacco *Use (packs per day, years smoked, smokeless tobacco use)*	Occupation *(student or other)*	Religious Preference

Remarks *(Attach additional sheet if needed)*

CONSENT FOR MINOR CADET PARTICIPATION, MEDICATIONS, TREATMENT

I give permission for full participation in CAP programs, subject to any limitations noted herein.

My signature below evidences my consent for my child/ward to possess and self-administer the prescription medications listed above I understand that there are legal limitations imposed on CAP senior members with regard to the involuntary administration of medications to my child/ward. (Cross out if permission is denied).

In case of emergency, I understand every effort will be made to contact me. 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. Medical providers are authorized to disclose to the adult in charge exam/test results and treatment provided.

________________ DATE

________________________________ SIGNATURE OF PARENT/GUARDIAN

CADETS UNDER 18 ONLY

PERMISSION FOR PROVISION OF MINOR CADET OVER-THE-COUNTER MEDICATION

This form may not be usable in some states due to statutes concerning who can administer medications and administration conditions. Wings with such restrictions will publish appropriate additional guidance in a supplement to CAPR 160-1.

Name *(Last, First, Middle)*	**Grade**	**CAPID**	**Charter Number**

Over-The Counter/Non-Prescription Medications

The following over-the counter medications may be administered according to package directions by CAP senior members. Cross out any medications not approved.

Acetaminophen (Tylenol) for fever or pain

Ibuprofen (Advil, Motrin) for fever or pain

Bacitracin or Neosporin antibiotic ointment to prevent infection

Hydrocortisone anti-inflammatory rash cream

Calamine/Caladryl for poison ivy itch relief

Antifungal creams and sprays for treatment of fungal rashes

Visine eye drops for dry, irritated eye relief

Op-Con A eye drops for allergic conjunctivitis

Benadryl liquid/tabs for allergic reactions

Claritin antihistamine for seasonal allergies

Robitussin products for relief of cough and cold symptoms

Delsym to suppress cough

Tums or Maalox for relief of stomach upset

Allergies

My child/ward has the following allergies or reactions to over-the-counter medications (list type of reaction):

Consent For Minor Cadet To Receive Over-The-Counter Medications

My signature below evidences my consent for CAP senior members to provide over-the-counter non-prescription medications (such as those listed above) to my child/ward if indicated in the reasonable judgment of such senior members. I understand that I will be informed if any such medications are administered.

Date	**Signature of Parent/Guardian**

DEPARTMENT OF THE AIR FORCE
105TH AIRLIFT WING (ANG)
ONE MAGUIRE WAY
NEWBURGH NY 12550-5075

ALL ENCAMPMENT MEMBERS (SENIORS AND CADETS) MUST COMPLETE THIS FORM

MEMORANDUM FOR 105OG/CC

MEMBER NAME: ☐

SUBJECT: 105th Airlift Wing (AW) Commander's Orientation Flight Program Medical Screening

1. As per (DAFMAN 48-123 Para 5.4.9.4.), military and civilian orientation flight candidates scheduled to fly in non-ejection seat aircraft will answer a locally generated health screening questionnaire which asks the candidate:

   a. Do you have any medical problems? YES ☐ NO ☐

   b. Are you on a duty limiting profile? YES ☐ NO ☐

   c. Do you take any medications? YES ☐ NO ☐

   d. Do you feel you need to see a Flight Surgeon (FS)? YES. ☐ NO ☐

2. The flying unit will refer those candidates with a positive response (YES) on any of the questions to the FS for review, appropriate medical examination if deemed necessary and medical recommendation for the orientation flight.

Indicate further information for any questions that were answered YES:

☐

DEPARTMENT OF THE AIR FORCE
105TH AIRLIFT WING (ANG)
ONE MAGUIRE WAY
NEWBURGH NY 12550-5075

CADETS UNDER 18 ONLY

MEMORANDUM FOR 105OG/CC

SUBJECT: 105th Airlift Wing (AW) Commander's Orientation Flight Program Permission Slip

1. As per (AFI 11-402 ANG Supplement Table 1.2.), Junior ROTC students are eligible for orientation flights in non-ejection seat aircraft. Orientation flight program details are listed on Orientation Flight Program memorandum.

2. Passengers on orientation flights under 18 years of age require parental/guardian approval in writing.

Name: ____

DOB: ____

Parent/Guardian Name (Printed) ____

Parent/Guardian Name (Signed) ____ Date ____________

ALL NON-STAFF CADETS

Syracuse University – Department of Recreation Services

Assumption of Risk, Waiver of Liability and Medical Authorization

Syracuse University offers a challenge course, consisting of a series of teambuilding activities, including but not limited to; low and high elements, field games and initiatives. These activities can be physically demanding and offer inherent risks. I accept responsibility for deciding if any pre-existing medical condition should limit my participation in these activities. It is not possible to anticipate all risks that could occur during this activity, but I accept all risks that could cause injury and death. If I am uncomfortable with engaging in any event or do not understand the instructions for any event, I will inform a facilitator, and will not participate in that event.

All participants in the challenge course could be exposed to the possibility of physical injury including death and disability. By signing this waiver each participant accepts the risk and responsibility as their own. By participating in the challenge course, the participant waives and releases any and all rights and claims for damages that the participant or his/her heirs or successors may have against Syracuse University and its trustees, officers, employees, students, agents, contractors and representatives arising out of or resulting from the participant's participation in the challenge course.

I understand and agree that this waiver is to be as broad and inclusive as is permitted by the laws of the State of New York, and that if any portion of this waiver is held invalid, the remaining terms shall continue in full force and effect. This waiver shall be binding upon me, as well as my successors, personal representatives, heirs and assigns.

In the event of any suspected injury or medical condition that requires immediate attention, I consent to treatment by Syracuse University and its facilitators. If treatment becomes necessary, I agree to pay for any such treatment, including treatment received from any other health care provider, and including the cost of transportation to a medical facility.

Age and Weight Restrictions

For Climbing Elements Only: Participants must be at least 7 years old and weigh at least 50 pounds but not more than 300 pounds.

Please check the appropriate boxes below as they pertain to you on the date of the scheduled program:

___ I hereby confirm that I / participant is seven (7) years old or greater

___ I hereby confirm that I / participant weigh(s) at least fifty (50) pounds and no more than three hundred (300) pounds

Media and Publicity Release

I acknowledge that Syracuse University may utilize photographs and / or video that may be taken of me or statements that I may make during the activity for promotional or educational purposes. I consent to this use and waive all rights to compensation.

Please check only one of the following options, then sign and date.
If under the age of 18, a parent or guardian must sign for any media to be used.

___ I hereby give consent to the above media and publicity release

___ I decline consent to the above media and publicity release

Check only one!

In consideration for participation in this activity, I agree to the terms above. I understand that this is a binding legal document.

School, Company or Organization Name: New York Wing Encampment, Civil Air Patrol

Participant's Name (print): ______________________________ DOB: ____________________

Participant's Signature: ____

Parent/Guardian Signature if under 18 years of age: ______________________________ *Date:* __________

Parent/Guardian Name (print): ______________________________ *Email:* ____________________

Phone Numbers (Home) ______________ (Work) ______________ (Cell) ______________

Name of Emergency Contact: ______________________________ Phone: ____________________