

27. Additional Remarks:

INSTRUCTION FOR COMPLETION OF CAP FORM 17

NOTE: Use of this form is optional at the discretion of the activity director (see CAPR 50-17, para 2-7b2).

See CAPR 50-17, *CAP Senior Member Professional Development Program*, for additional information and instructions.

1. APPLYING FOR ACTIVITIES:

a. For region level activities, unit commander verifies the information, makes recommendation, signs the application, retains a copy, and forwards the original to wing headquarters. Wing commander verifies application, makes recommendation, signs the application, retains a copy, and forwards the original to region headquarters for final approval by region commander.

b. For selected national level activities, unit commander verifies the information, makes recommendation, signs the application, retains a copy, and forwards the original to wing headquarters. Wing commander verifies application, makes recommendation, signs the application, retains a copy, and forwards the original to region headquarters for action (if applicable). Region commander makes recommendation, assigns selection number, signs the application, retains a copy, and forwards original to NHQ CAP/PD.

2. COMPLETING THE FORM:

Blocks 1-11, 13-15, 19-20 are self explanatory.

Block 12. Enter the month and year of Level I completion. (Example: Feb 92)

Block 16. List each specialty and the highest rating completed in that specialty. (Example: Enter 213-2 for Emergency Services Officer - Senior Level, or enter 201-1 for Public Affairs - Technician Level.)

Block 17. List names and dates of training activities such as SAR exercises, SLS, AFIADL Course-13, RSC, ACSC, AWC, etc. Use Additional Remarks section above or add additional sheet if necessary.

Block 18. List training awards only along with completion dates. (Example: Garber Award Aug 90.)

Block 21. List physical handicaps or ailments for which the applicant will be taking medication during the activity or which might affect the applicant's level of participation in activities. Provide a list of medication taken regularly. Use Additional Remarks section or add additional sheet if necessary.

Block 24. For Unit Commander.

Remarks are intended for consideration by the wing commander. Use Additional Remarks section or add additional sheet if necessary.

Block 25. For Wing Commander.

For National Staff College (NSC), wing commander approves for personnel assigned within their wing, then forwards to NHQ CAP/ETP. Use Additional Remarks section or add additional sheet if necessary.

Block 26. For Region Commander.

For National Staff College (NSC), this block is completed by region commander only for those members currently serving on the region staff, and then forwarded to NHQ CAP/PD. Remarks are intended for consideration by National Headquarters. Use Additional Remarks section or add additional sheet if necessary.

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 <i>(Last, First, Middle)</i>			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	
<input type="checkbox"/>	<input type="checkbox"/>	Decreased vision, glaucoma, contacts	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurring injuries
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections, perforation	<input type="checkbox"/>	<input type="checkbox"/>	Activity, mobility restrictions
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty equalizing ears	<input type="checkbox"/>	<input type="checkbox"/>	Use of cane, walker, wheelchair
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss, hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Back or neck pain or injury
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	Migraine or severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis, serious allergic reaction	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, emphysema (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Head injury, unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	Ever use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizure
<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath with activity	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, chest pain, angina	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems (low or high)
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur, heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, high or low blood sugars
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Irregular or rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease, hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness
<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble, ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Special diet, food allergies
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Current bedwetting problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea, constipation	<input type="checkbox"/>	<input type="checkbox"/>	ADD (Attention Deficit Disorder)
<input type="checkbox"/>	<input type="checkbox"/>	Hernia or rupture	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness (bipolar, other)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression, anxiety, suicidal
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems (men)	<input type="checkbox"/>	<input type="checkbox"/>	Admission to the hospital
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Other chronic medical illnesses
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps (women)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder, sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	Broken bone, joint problems	<input type="checkbox"/>	<input type="checkbox"/>	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

EMERGENCY INFORMATION (Insurance/Physician Information, Emergency Contacts, Minor Consents)				
Name <i>(Last, First, Middle)</i>		Grade	CAPID	Charter Number
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
<i>(Area Code)</i> Home Phone		<i>(Area Code)</i> Cell Phone		
Primary Insurance Information <i>(Please attach copy of insurance cards, front and back)</i>				
Medical Insurance Company	Policy Number	Group Code/Number	Co-Pay Amount \$	
Prescription Coverage Company	Policy Number	Group Code/Number	Co-Pay Amount \$	
Family Physician				
Name			<i>(Area Code)</i> Phone	
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
Emergency Contact <i>(Parent, guardian or closest relative to be notified in case of emergency)</i>				
Name			Relationship to Applicant	
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
<i>(Area Code)</i> Pager	<i>(Area Code)</i> Cell/Mobile Phone	<i>(Area Code)</i> Day Phone	<i>(Area Code)</i> Night Phone	
Unit Commander Name and Grade		Unit Name		
<i>(Area Code)</i> Unit Commander Day Phone		<i>(Area Code)</i> Unit Commander Night Phone		



DEPARTMENT OF THE AIR FORCE
AIR DOMINANCE CENTER SAVANNAH
1401 ROBERT B. MILLER JR. DRIVE
GARDEN CITY GEORGIA 31408

**CONSENT AND HOLD HARMLESS AGREEMENT AND RELEASE OF LIABILITY
AGENCY OR INDIVIDUAL**

The undersigned hereby request to use facilities and (or) equipment of the Georgia Air National Guard, which may be in conjunction with other activities, agencies, organizations, or sponsors:

Civil Air Patrol Georgia Wing Summer Encampment 2021

Date(s): 18-24 July 2021

I understand the nature and scope of these activities.

I agree to not hold the United States of America, the State of Georgia, the Air National Guard, any other agency, organization, or sponsor of these activities, or their officers, members, agents, or employees, responsible for any harm or injury, from any cause, which may befall me related to or arising out of participation in these activities or any transportation related to said activities, and hereby release said entities and persons from any liability relating thereto. I further agree to indemnify and hold said entities and persons harmless from the claims or causes of action asserted by any other persons on my behalf, or in their own right, arising out of said use of facilities and (or) equipment or participation in activities or transportation provided by or conducted on Air National Guard Facilities. I similarly agree to hold said entities and persons harmless from the claims of other persons arising out of any acts done by me. I agree that these conditions and agreements are binding on all my heirs, executors, administrators, representatives, assignees, and successors in action.

I have read and understand the above, and willingly agree to said terms and conditions.

SIGNATURE: _____ DATE: _____

ADDRESS: _____ PHONE: _____

C-130 Orientation Flight Permission Slip

The following permission procedure has been accepted as the 165th OSF/OSO procedure and must be administered consistently by all individuals.

Student Name: _____

Permanent Address: _____

Organization: _____ Civil Air Patrol Georgia Wing _____

Activity: _____ C130 Orientation Rides _____

Known Medical Conditions: _____

I hereby give my permission for _____ to participate in a C-130 Orientation Flight, departing on _____ and returning approximately _____. I further understand that this is done with my express approval and at my own risk, but know that the Georgia Air National Guard will make every effort to ensure the safety and wellbeing of the students going on the trip.

Parent/Guardian Signature: _____ Date: _____

In addition, each passenger must complete the following Air Transportation Agreement:

For and in consideration of being permitted to fly as a passenger in aircraft operated by or on behalf of the United States of America, for and on behalf of myself, my personal representatives, heirs and assigns, I hereby release and discharge the United States, its agents, servants, or employees from any and all claims for property damage and/or personal injury or death from or during said flight or flights or continuance thereof or from ground operations incident thereto.

Print Name: _____ Date: _____

Signature (Parent/Guardian if under 18): _____

CAP Instructor Signature: _____

Name and Address of Person to be notified in Emergency: _____

