

## CALIFORNIA WING – APPLICATION FOR CAP ACTIVITY

CAP ID NUMBER (6 DIGITS)	REGION	WING	GROUP	SQUADRON	CHARTER # <b>CA-???</b>	<input type="checkbox"/> CADET	<input type="checkbox"/> MALE
						<input type="checkbox"/> SENIOR	<input type="checkbox"/> FEMALE
NAME (LAST, FIRST MIDDLE INITIAL)				CAP GRADE	DATE JOINED CAP MMM-YYYY	HOME TELEPHONE (WITH AREA CODE)	
MAILING ADDRESS (NUMBER & STREET)				APARTMENT OR SPACE NUMBER		BUSINESS TELEPHONE (WITH AREA CODE)	
CITY				STATE	ZIP CODE	CELL PHONE NUMBER (WITH AREA CODE)	
DATE OF BIRTH (dd MMM yy)	HEIGHT	WEIGHT	SCHOOL GRADE (CADETS ONLY)	EMAIL ADDRESS			
ACTIVITY REQUESTED (ONE ACTIVITY PER APPLICATION, PLEASE)			LOCATION		DATE (dd-MMM-yy)		
RELIGIOUS PREFERENCE		ARE YOU INTERESTED IN ATTENDING RELIGIOUS SERVICES IF AVAILABLE? YES <input type="checkbox"/> NO <input type="checkbox"/>			<b>Cadet Protection Training (18 AND OLDER ONLY)</b> Completed <input type="checkbox"/> Will be completed by activity <input type="checkbox"/>		
TRANSPORTATION: <i>ARRIVE</i> BY: PRIVATE VEHICLE <input type="checkbox"/> CAP VAN <input type="checkbox"/> TRAIN <input type="checkbox"/> BUS <input type="checkbox"/> AIRPLANE <input type="checkbox"/>					SCHEDULE/FLIGHT/ARRIVAL LOCATION		
DRIVER'S NAME:							
TRANSPORTATION: <i>RETURN</i> BY: PRIVATE VEHICLE <input type="checkbox"/> CAP VAN <input type="checkbox"/> TRAIN <input type="checkbox"/> BUS <input type="checkbox"/> AIRPLANE <input type="checkbox"/>					SCHEDULE/FLIGHT/DEPARTURE LOCATION		
DRIVER'S NAME:							
I WOULD LIKE TO ATTEND THIS ACTIVITY AS A: <input type="checkbox"/> Student/Participant <input type="checkbox"/> Cadet Staff Member – POSITION REQUESTED : _____ <input type="checkbox"/> Senior Staff Member – POSITION REQUESTED: _____					T-SHIRT SIZE (SOME ACTIVITIES MAY PROVIDE T-SHIRTS)  S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> 2XL <input type="checkbox"/>		
Special Meals Required ( <i>Special meals may not be able to be accommodated</i> ) What kind?							
<b>SENIORS ONLY - PARTICIPATION:</b> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Part-Time Dates: _____							
<b>PAYMENT OF EVENT FEES:</b> I have included payment of \$ _____ in the form of: Cash: <input type="checkbox"/> Check: <input type="checkbox"/> Money Order: <input type="checkbox"/> Credit Card: <input type="checkbox"/> (attach/enclose CAWGF14 or online receipt)						CAWG Use Only	
Comments:							
Emergency Contact During Activity – Parent, Guardian, or closest relative to be contacted in case of emergency			Daytime Phone – MUST be available during activity		Evening Phone – MUST be available during activity		

NAME (LAST, FIRST MI)	<input type="checkbox"/> CADET <input type="checkbox"/> SENIOR	CAPID	ACTIVITY	DATE OF ACTIVITY
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### RELEASE AGREEMENT

KNOW ALL MEN BY THESE PRESENTS that I am submitting my application for Civil Air Patrol Special Activities or Encampments, and I hereby volunteer entirely upon my own initiative, risk, and responsibility for an assignment to participate in this activity or encampment at the first available opportunity and with full knowledge that such activity may include:

1. Traveling by land, sea, or air in US military, commercial, or privately owned vehicles from regular place of residence to the site of the activity or encampment, travel incident to the activity or encampment, and subsequent return to place of residence.
2. Participation in aeronautical activities as a passenger or student trainee in US military, commercial, or privately owned aircraft.
3. Living for a period of one week or more on diminished rations and minimal shelter simulating actual survival conditions.
4. Being quartered and/or subsisting away from regular or normal place of residence for an extended period of time.
5. Remaining with the cadet group I am assigned to at all times during the activity or encampment.
6. Acting as a spokesman for Civil Air Patrol, rendering reports on the activity or encampment.
7. Refraining from argumentative discussions concerning governmental policies.

In consideration of the permission extended to me by the Civil Air Patrol/United States of America through its officers and agents to participate in such 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, actions, or causes of action, on account of my death or on account of any injury to me or my property which may occur as a result of the negligence of Civil Air Patrol/United States of America, its agents or employees during said activity/encampment or activities/encampments or continuances thereof, as well as all ground and flight operations incident thereto.

\_\_\_\_\_  
Social Security Number – Only if requested

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF APPLICANT

### RELEASE BY PARENT OR GUARDIAN

KNOW ALL MEN BY THESE PRESENTS: 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 as a result of the negligence of the Civil Air Patrol/United States of America, its agents or employees 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:

1. Is my child or ward.
2. Has no history or injury or disease which might be affected by this activity except those previously noted in the Medical Information section of this form and is able to participate without the physical/emotional support of others. Also, he/she is capable of taking any prescribed medications without supervision.
3. 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 he/she does not follow the activity/encampment rules, regulations, and directives he/she may be sent home at the discretion of the project officer, encampment commander or activity director at my expense.
4. Should firearms training be offered as outlined in CAPR 52-16, permission is hereby given for the applicant to participate.

However, in case of injury, disease or other illness, permission is hereby granted to treat the participant 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

\_\_\_\_\_  
FATHER OR LEGAL GUARDIAN

\_\_\_\_\_  
WITNESS FOR FATHER'S SIGNATURE  
(Must be signed by adult other than parent/legal guardian)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
MOTHER OR LEGAL GUARDIAN

\_\_\_\_\_  
WITNESS FOR MOTHER'S SIGNATURE  
(Must be signed by adult other than parent/legal guardian)

### UNIT COMMANDER'S CERTIFICATION

To my knowledge:

1. I certify that **ALL** of the information on this form is complete and correct.
2. This applicant meets the activity prerequisites and is prepared to attend this activity.
3. This applicant has no history or injury or disease which might be affected by this activity except those previously noted in the Medical Information section of this form.
4. This applicant 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 he/she does not follow the activity/encampment rules, regulations, and directives he/she may be sent home at the discretion of the project officer, encampment commander or activity director at **parental or unit expense**.

\_\_\_\_\_  
ACTIVITY/LOCATION

\_\_\_\_\_  
DATE

\_\_\_\_\_  
UNIT COMMANDER'S SIGNATURE

## MEDICAL INFORMATION (FOUO) - TO BE COMPLETED BY ALL APPLICANTS

NAME OF PARTICIPANT (Last, First Middle Initial)		<input type="checkbox"/> CADET <input type="checkbox"/> SENIOR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CAPID
ACTIVITY	LOCATION	DATES		
DO YOU CURRENTLY USE ANY MEDICATION? (Including eye drops) <input type="checkbox"/> NO <input type="checkbox"/> YES (List any medication taken and the reason in the remarks section.)				
HAVE YOU BEEN INVOLVED IN AN ACCIDENT REQUIRING MEDICAL TREATMENT IN THE PAST FIVE YEARS? <input type="checkbox"/> NO <input type="checkbox"/> YES (Explain the extent of your injuries and treatment required in the remarks section.)				
MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS OTHER THAN REGULAR OFFICE VISITS OR PHYSICALS? <input type="checkbox"/> NO <input type="checkbox"/> YES (Explain the extent of your injuries and treatment required in the remarks section.)				
HAVE YOU HAD OR HAVE NOW ANY OF THE FOLLOWING? (If yes is answered on any items, please explain why in the remarks section with dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with performance during the special activity or encampment should be documented in the remarks section.)				
1. Tuberculosis <input type="checkbox"/> N <input type="checkbox"/> Y	10. Knee trouble (locking, giving out, pain, etc.) <input type="checkbox"/> N <input type="checkbox"/> Y	19. Period of unconsciousness or concussion <input type="checkbox"/> N <input type="checkbox"/> Y		
2. Asthma or breathing problems related to exercise, weather, pollens, etc. <input type="checkbox"/> N <input type="checkbox"/> Y	11. Knee or foot surgery <input type="checkbox"/> N <input type="checkbox"/> Y	20. Heart trouble or murmur <input type="checkbox"/> N <input type="checkbox"/> Y		
3. Shortness of breath <input type="checkbox"/> N <input type="checkbox"/> Y	12. Any need to use corrective devices such as prosthetic devices, braces, back supports, lifts, etc.) <input type="checkbox"/> N <input type="checkbox"/> Y	21. Nervous trouble (anxiety or panics attacks) <input type="checkbox"/> N <input type="checkbox"/> Y		
4. Wheezing or problems with wheezing <input type="checkbox"/> N <input type="checkbox"/> Y	13. Stomach, liver, intestinal trouble, or ulcer <input type="checkbox"/> N <input type="checkbox"/> Y	22. Depression or excessive worry <input type="checkbox"/> N <input type="checkbox"/> Y		
5. Been prescribed or used an inhaler <input type="checkbox"/> N <input type="checkbox"/> Y	14. High or low blood sugar <input type="checkbox"/> N <input type="checkbox"/> Y	23. Inability to stand, sit, kneel, lie down, etc. <input type="checkbox"/> N <input type="checkbox"/> Y		
6. Ear, nose, or throat trouble <input type="checkbox"/> N <input type="checkbox"/> Y	15. Adverse reaction to serum, food, insect sting/bites, or medicine <input type="checkbox"/> N <input type="checkbox"/> Y	24. Any drug or narcotic habit <input type="checkbox"/> N <input type="checkbox"/> Y		
7. Painful shoulder, elbow, or wrist (pain, dislocation, etc.) <input type="checkbox"/> N <input type="checkbox"/> Y	16. Frequent or severe headaches <input type="checkbox"/> N <input type="checkbox"/> Y	25. Attempted suicide <input type="checkbox"/> N <input type="checkbox"/> Y		
8. Impaired use of arms, legs, hands, or feet <input type="checkbox"/> N <input type="checkbox"/> Y	17. Seizures or convulsions; epilepsy <input type="checkbox"/> N <input type="checkbox"/> Y	26. Severe menstrual cramps ( <i>Females only</i> ) <input type="checkbox"/> N <input type="checkbox"/> Y		
9. Chronic or recurring injuries <input type="checkbox"/> N <input type="checkbox"/> Y	18. Motion sickness <input type="checkbox"/> N <input type="checkbox"/> Y	27. Are you currently in good health <input type="checkbox"/> N <input type="checkbox"/> Y		
IMMUNIZATIONS <input type="checkbox"/> Up-to-Date <input type="checkbox"/> Exceptions:		MEDIC ALERT® ID NUMBER (If worn):		
FAMILY / PRIMARY PHYSICIAN	Address	Phone		
MEDICAL INSURANCE INFORMATION COMPANY:		<b>INSTRUCTIONS FOR CAPF150-MED)</b> <i>Completed Medical Information Forms are For Official Use Only (FOUO).</i> Information gathered in this form shall not be accessed by anyone without a need-to-know, such as: project officers, activity commanders, medical officers and physicians. The project officer/commander is responsible to properly protect this sensitive medical information.		
POLICY NUMBER:				
Emergency Contact During Activity – Parent, Guardian, or closest relative to be contacted in case of emergency	Daytime Phone – MUST be available during activity	Evening Phone – MUST be available during activity		
REMARKS (Please include any drug or food allergies and all prescription or OTC medication. Describe what the medication is treating and severity of food allergies, if any. This information is very important to treating physicians).				