AFJROTC PERMISSION FORM
MOUNTAINEER CADET OFFICER LEADERSHIP SCHOOL
OVERNIGHT TRIP

My son/daughter, __________________________________________, has my permission to (Name)
go on a field trip to Concord University, Athens, West Virginia, from 13-20 June 2020.

I understand that if my son/daughter becomes ill or injured during this trip, chaperones will attempt to contact me or an emergency contact at the numbers listed below:

Parent/Guardian Name _____________________________Home # (___) _____________

Mother’s Work # (___) ____________ Father’s Work # (___) _____________

Mother’s Cell # (___) _____________ Father’s Cell # (___) _____________

If I cannot be reached, I understand and agree that my son/daughter may be taken for medical assistance and I agree that I will be solely responsible for any and all costs incurred as a result.

I give permission for photographs to be taken of my child during the school. Cadets take these photographs as they would on any other trip or vacation. Instructors will take pictures for documenting the week, an end-of-school/week presentation, and academic lessons at the home unit.

I have read Chapters One and Two of the Cadet Handbook and understand the behavior expectations for MCOLS. I understand MCOLS has a zero tolerance policy towards the possession, use or consumption of drugs, alcohol, tobacco, vaping devices or weapons. I understand possession of electronic devices (i.e., cellular phone, MP3 Player, Tablet, Smart Watch, etc.), are grounds for immediate disenrollment. All medications (to include over the counter drugs/vitamins) are to be turned in when cadets in-process (exceptions include epi-pens and inhalers as documented by a physician). Any cadet found in possession of any unauthorized medication will face immediate disenrollment. Cadets and their rooms/luggage are subject to search if probable cause exists to believe they are in possession of unauthorized/prohibited items. All areas of cadet rooms (to include closets and drawers) are subject to daily inspection.

I further agree to indemnify and hold harmless the school district and its employees, Concord University and its employees, and the United States Air Force for any injury that occurs to my child, which is not the result of action or inaction by any of the above parties or representatives.

____________________________________________ ________________________
(Signature of Cadet) (Date)

____________________________________________ ________________________
(Signature of Parent/Guardian) (Date)
MEMORANDUM OF AGREEMENT

As the parent(s) or guardian(s) of ____________________________, who will attend the Mountaineer Cadet Officer Leadership School, I/we agree I/we shall pick-up our child at Concord University, Athens, West Virginia, immediately (within 8 hours) if disenrolled or released.

I/We understand that disenrolled or released cadets cannot remain at Concord University.

I/We agree in the event I/we cannot pick up our child within 8 hours, I/we shall make travel arrangements suitable to the commandant, for my/our child to begin travel within the 8 hour period.

I/We agree I/we shall be available for the entire period of the Mountaineer Cadet Officer Leadership School to fulfill this responsibility.

I/We understand that any transportation is at my/our expense and that all fees paid are non-refundable

I/We understand this completed memorandum of agreement is a condition for the above named child to be eligible to attend the Mountaineer Cadet Officer Leadership School.

_________________________  
Printed Name

_________________________   ______________  
Signature        Date

_________________________  
Printed Name

_________________________   ______________  
Signature   Date
AFJROTC Parental Consent Form
Release, Indemnity, and Assumption of Risk

Air Force Junior Reserve Officer Training Corps (AFJROTC) will arrange for and provide a Cadet Leadership Course activity (hereafter, “Activity”). The purpose of the Activity is to introduce the cadet to basic leadership skills, physical fitness skills, marching, survival skills, leadership reaction courses, community service, and outdoor compass navigation techniques.

Printed Name of Child: ______________________________________________________________

AFJROTC Unit # and School District: __________________________________________________

I agree to assume the risk that unexpected events may occur and result in harm, injury, death, or illness to my child or damage to my property or my child’s property while my child is participating in or observing the Activity, or traveling to or from the Activity. I agree, on my behalf and on behalf of my child, to indemnify AFJROTC, ____________________________________________, and the school district: ________________________________________________________ and each of their employees, members, agents, affiliates, successors and assigns (collectively, the “Indemnified Parties”) and not to sue the Indemnified Parties for any harm, injury, death, or illness, to my child or damage to my property or my child’s property associated with my child’s participation in, observation of, or travel to/from the Activity. I understand that my child’s participation in the Activity is voluntary. I attest that my child is physically and mentally capable to participate in the Activity.

If my child requires emergency medical treatment, please contact:

Name of Emergency Contact Person: _____________________________________________

Cell Phone: __________________________ Work Phone: _____________________________

If the Emergency Contact Person I have listed is not available, please contact:

Doctor: ___________________________ Phone: _________________________________

I consent to the provision of emergency medical treatment for my child to the extent that the treatment is necessary in the medical opinion of the medical provider rendering the treatment.

By signing below, I grant permission for my child to participate in the Activity described above. This Release, Indemnity, and Assumption of Risk statement covers all events associated with the Activity. If I have any concerns about my child’s ability to participate, I agree to discuss my concerns with my child’s instructor or, if appropriate, with my child’s physician before signing this form.

Printed name of Parent or Legal Guardian: ___________________________________________

Signature of Parent or Legal Guardian: ___________________________________________ Date: __________

The information herein is For Official Use Only (FOUO) information which must be protected under the Freedom of Information Act (5 U.S.C. § 522) and/or the Privacy Act of 1974 (5 U.S.C., §552a), as amended. Unauthorized disclosure or misuse of this PERSONAL INFORMATION may result in disciplinary action, criminal and/or civil penalties.
Parental/Guardian Photo Release Form

We (Air Force Junior ROTC) are sending you this parental consent form to request permission to use your child’s photo/image and name for US Air Force advertising purposes to include on social and other media.

Please check one of the following choices:

☐ I GRANT permission for my child’s photos/images and name to be used for US Air Force advertising purposes to include on social and other media.

☐ I DO NOT GRANT permission for photos/images of my child to be used for US Air Force advertising purposes to include on social and other media.

Student’s Name: (please Print) ____________________________________________

Printed name of Parent/Guardian: __________________________________________

Signature of Parent/Guardian: ____________________________________________

Address: _________________________________ City: _________________________

State: __________________ Zip Code: __________________

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LIMITED POWER OF ATTORNEY FOR MEDICAL TREATMENT OF A MINOR

STATE OF_______________________________

COUNTY OF_______________________________

IN CASE OF EMERGENCY or medical issue beyond the ability of the medical staff provided by the Air Force Junior ROTC Instructors operating the Mountaineer Officer Cadet Officer Leadership School at Concord University, Athens, West Virginia, I

__________________________________________

hereby give permission for the instructors to secure proper treatment for, hospitalize, and to order injection, and/or anesthesia, and/or surgery for my child

__________________________________________

Signature of Parent/Guardian_______________________________ Date____________

The foregoing instrument was acknowledged by me this _____ day of _________________ by

_______________________________    Seal:
(Typed or Printed Name of Parent or Guardian)

_______________________________    Seal:
Notary Public Signature

My Commission Expires__________________________
PHOTO COPY OF CADET’S MEDICAL INSURANCE CARD OR FORM
(FRONT AND BACK)

Cadet’s Name ______________________________________________
MOUNTAINEER CADET OFFICER LEADERSHIP SCHOOL
HEALTH FORM

USE THE SPACE AT THE BOTTOM OF THE NEXT PAGE TO PROVIDE ADDITIONAL INFORMATION OR TO SPECIFY A SITUATION

PLEASE PRINT CLEARLY

Last Name ________________________________ First Name ________________________________
Birth Date ______________ Weight _________ Height __________  Gender □ Male □ Female

Check All That Apply

<table>
<thead>
<tr>
<th>Health History</th>
<th>Diseases</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ Asthma</td>
<td>__ Chicken Pox</td>
<td>__ Insect Stings/Bites</td>
</tr>
<tr>
<td>__ Frequent Ear Infections</td>
<td>__ Measles</td>
<td>__ Hay Fever</td>
</tr>
<tr>
<td>__ Heart Defect/Disease</td>
<td>__ German Measles</td>
<td>__ Poison Ivy, etc</td>
</tr>
<tr>
<td>__ Convulsions</td>
<td>__ Mumps</td>
<td>__ Sunscreen (Must be Used)</td>
</tr>
<tr>
<td>__ Diabetes</td>
<td></td>
<td>__ Penicillin</td>
</tr>
<tr>
<td>__ Blood/Clotting Disorders</td>
<td></td>
<td>__ Other Drugs – specify</td>
</tr>
<tr>
<td>__ Hypertension</td>
<td></td>
<td>__ Food – specify</td>
</tr>
<tr>
<td>__ Fainting</td>
<td></td>
<td>__ Other – specify</td>
</tr>
<tr>
<td>__ Mononucleosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of last tetanus shot ____________________________________________

MEDICATIONS BEING TAKEN

□ This cadet takes NO medication on a routine basis.

□ This cadet routinely takes prescription or over-the-counter medication.

Does the cadet use an inhaler for asthma or other breathing condition? □ yes □ no

Does the cadet use an EPI pen for allergic reactions? □ yes □ no

LIMITATIONS WE SHOULD KNOW ABOUT:

Physical:___________________________________________________________

Mental or emotional: _______________________________________________

Has the cadet ever required any psychological counseling or hospitalization? □ yes □ no

Does the cadet require psychotropic medication? □ yes □ no

If “YES”, explain ____________________________________________________

________________________________________________________

MCOLS 2020
Special dietary needs: ________________________________________________________________

Sleepwalking? □ yes □ no Other □ yes □ no (Specify ____________________)

Parent or Guardian________________________________________ Relation ________________

Home Address__________________________________________ Phone # ______________

________________________________________________ Cell # ______________

Business Address_______________________________________ Phone # ______________

2nd Parent or Emergency Contact __________________________ Relation ______________

Home Address__________________________________________ Phone # ______________

________________________________________________ Cell # ______________

Business Address_______________________________________ Phone # ______________

Other Emergency Contact: ________________________________ Phone # ______________

Cell # ______________

Cadet’s Doctor __________________________________________ Phone # ______________

Cell # ______________

Doctor’s Address ________________________________________

Family has insurance with__________________________________________________________

Policy number _________________________________________

If group insurance, please complete:

Employer’s name _______________________________________

Employer’s address_____________________________________

ADDITIONAL INFORMATION
AFJROTC Cadet Health/Wellness Program is designed to work with your child to help them improve their physical fitness. All physical activity sessions will be supervised and monitored by at least one of our instructors. These sessions include walking, running, and calisthenics exercises. The AFJROTC instructors have been trained in administering CPR if needed.

By granting permission, we understand there are risks associated with any physical activity. It is our responsibility to inform the JROTC instructors of anything that should keep our child from participating in the AFJROTC Cadet Health/Wellness Program. In the event of a medical problem, we understand that any medical care that may be required is our personal financial responsibility.

It is mandatory to complete this screening form prior to participating in the Cadet Health/Wellness Program. Return this completed questionnaire to your SASI or ASI, and advise them if you responded “Yes” to any of the questions below.

1. Has there been any significant change to your health in the past 6 months? YES - NO
2. Are you currently on a medical profile exempting you from PT activities? YES - NO
3. Has a physician ever indicated you have heart disease, heart or breathing troubles?
   a. Do you suffer from pains in your chest, especially with physical activity? YES - NO
   b. Do you feel faint or have dizzy spells during or after physical activity? YES - NO
   c. Do you have shortness of breath related to asthma or any other condition that exercise could aggravate? YES - NO
4. Have you experienced a significant weight change in the past 6 months? YES - NO
   If “Yes”, indicate the estimated amount: Gained/lost _____ lbs.
5. Have you ever been diagnosed or displayed symptoms of heat stress? YES – NO
6. Do you take any dietary, herbal or nutritional supplements, which contain any of the following substances: Ephedra/Ephedrine, Guarana, Phenylephrine, Pseudoephedrine? YES - NO
   If “Yes,” please list:___________________________________________________________
7. Do you have any other medical issues that may cause a safety concern during physical exercise? YES - NO
   physical exercise? (i.e., allergies, pregnancy, etc.)
   If “Yes,” please list:____________________________________________________________

NOTE: If cadet’s health status changes during this period, cadet will notify AFJROTC instructor.

This form is to gather information to be used for screening a candidate for participation as an AFJROTC cadet in the AFJROTC Cadet Health/Wellness Program. This form is for internal use only.

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Mountaineer Cadet Officer Leadership School (MCOLS)

Parent/Guardian Form for Assistance/Monitoring of Self-Administration of Over-the-Counter Medication

The MCOLS Clinic maintains a limited amount of over-the-counter medication for cadet use. A parent/guardian signature is required before a cadet can be assisted with the self-administration of medication or medication can be administered to the cadet.

Parents/guardians are to initial beside those medications their child may receive.

Parents/guardians are to line through any items their child may not receive.

<table>
<thead>
<tr>
<th>Cadet Name</th>
<th>Unit</th>
<th>Medication</th>
<th>Symptoms</th>
<th>Parent Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tylenol (Acetominophen)</td>
<td>Mild to moderate aches/pains/headache</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motrin (Ibuprofen)</td>
<td>Mild to moderate aches/pains/headache</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Aspirin</td>
<td>Mild to moderate aches/pains/headache</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Benadryl (Antihistamine/ Diphenhydramine HCL)</td>
<td>Allergic reactions/nasal congestion/allergies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tums (Calcium Carbonate)</td>
<td>Upset stomach</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mylanta</td>
<td>Antacid/Upset stomach</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dramamine</td>
<td>Mild nausea, mild vomiting, mild motion sickness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Calamine Lotion/Band-aid</td>
<td>Contact dermatitis</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Artificial Tears or Bausch &amp; Lomb Eye Wash (Sodium Chloride)</td>
<td>Eye irritations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cough drops (Cough Suppressant)</td>
<td>Cough</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cepacol Spray or Lozenges</td>
<td>Mild sore throat</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Anbesol Ointment/Orajel (Benzocaine)</td>
<td>Mouth ulcers/mild toothache</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Mineral Ice (Blue Ice)</td>
<td>Sore muscles/minor pains</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Antibacterial Ointment (Neosporin)</td>
<td>Minor cuts/abrasions</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Vaseline (Petroleum Jelly)</td>
<td>Skin irritations</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Aloe Vera, Aloe Gel, or sunscreen 15-30 SPF</td>
<td>Sunburn</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Desitin</td>
<td>Skin irritations/diaper rash</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Baby Oil/Dry Skin Lotion</td>
<td>Skin irritation/dry skin</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Immodium AD</td>
<td>Mild diarrhea</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sudafed</td>
<td>Nasal Congestion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dulcolax</td>
<td>Stool Softener</td>
<td></td>
</tr>
</tbody>
</table>

I give my permission for MCOLS Staff personnel to administer or monitor/assist in the self-administration of the medication that I have initialed. I certify that I am the parent/guardian of the above named child.

Parent Signature ___________________ Date _______________
Physician Form for Assistance with Self-Administration of Prescription Medication

**USE ONE FORM FOR EACH MEDICATION**

The following is to be completed by a health care provider (physician, nurse practitioner, dentist, etc). No medication of any kind will be given to your child unless this information is completed and turned in to the MCOLS staff during in-processing. All prescription medication must be in a pharmacy-labeled container.

All prescription medication will be turned-in during in-processing.

MCOLS medical staff will determine what medications a cadet can possess.

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**TO BE COMPLETED BY PARENT/GUARDIAN:**

Name of Cadet ______________________   Date of Birth _______

School _________________________  Grade ___________    AFJROTC Unit ____________

I give permission for my child to be assisted in the self-administration of the medication listed below by authorized MCOLS Staff. The MCOLS Staff has my permission to share the information provided with appropriate members of the educational team. This will be on a “need to know” only basis in a confidential manner. A parent/guardian signature includes permission for the MCOLS Staff to communicate with the provider listed below regarding any questions.

______   ___________________        __________    _________    __________________________

Date        Parent/ Guardian Signature    Home Phone   Work Phone    Emergency Contact Name/Phone

**TO BE COMPLETED BY PHYSICIAN:**

Name of Medication_____________________________ Dosage______________ Route_____________

Diagnosis/reason for which medication is given___________________________________________

If medication is to be given daily, at what time?  A.M.___________ P.M._____________

If medication is to be given “When needed”, describe symptoms or condition ________________

How soon can it be repeated? _______________________________   Is refrigeration necessary?   Yes /  No

Possible side effects___________________________ Termination Date for Self-Administration__________

Healthcare provider’s name (Please Print)____________________________________________________

Healthcare provider’s signature_____________________________________ Date__________________

Address_______________________________________________________ Zip code_______________

Telephone______________________________________________________ Fax___________________
Mountaineer Cadet Officer Leadership School (MCOLS)

Parent/Guardian Form for Assistance with Self-Administration of Over-the-Counter Medication

USE ONE FORM FOR EACH MEDICATION

Any required over-the-counter medication must be verified on this form by the parent or guardian. Over-the-counter medication must be brought to MCOLS in an unopened, labeled, original container.

A parent/guardian signature is required before a cadet can be assisted with the self-administration of medication or medication can be administered to the cadet.

All over-the-counter medication will be turned-in during in-processing.

MCOLS medical staff will determine what medications a cadet can possess.

TO BE COMPLETED BY PARENT/GUARDIAN:

Name of Cadet ______________________ Date of Birth _______

School _________________________ Grade ___________ AFJROTC Unit ____________

I give permission for my child to be assisted in the self-administration of the medication listed below by authorized MCOLS Staff. The MCOLS Staff has my permission to share the information provided with appropriate members of the educational team. This will be on a “need to know” only basis in a confidential manner. A parent/guardian signature includes permission for the MCOLS Staff to communicate with the provider listed below regarding any questions.

______ _____________________     __________    _________    _______________________
    Date       Parent/ Guardian Signature  Home Phone       Work Phone   Emergency Contact Name/Phone

TO BE COMPLETED BY PARENT/GUARDIAN:

Name of Medication_____________________________ Dosage______________

Diagnosis/reason for which medication is given________________________________________

If medication is to be given daily, at what time?  A.M.__________ P.M.____________

If medication is to be given “When needed”, describe symptoms or condition ________________

How soon can it be repeated? _______________________________

Termination Date for Self-Administration______________

Any other information that is necessary for this medication and your child.