Johnson City Schools
Field Trip Permission Form

Science Hill High School
Melanie Riden-Bacon, Principal
Dr. Richard Bales, Superintendent of Schools

Student: _____ **DOB:** _____ **Grade:** _____

Important Contact Information: Mother's Name: _____ Phone: _____
Fathers Name: _____ Phone: _____
Other Contact Name: _____ Phone: _____

_____ (Student's name) is a member of the Science Hill's JROTC (Organization) and has my permission to attend SLC (Activity) to be held in Camp Davey Crockett Whitesburg TN (Location) on 31 May - 6 June (Date). I agree to the following:

1. I have been provided with all necessary information regarding this field trip, including the purpose, date, approximate time of departure and return, travel plans, number of chaperones and personal expenses.
2. I understand that the teachers in charge of the classes proposing to make the trip will determine which students may participate, however, if a question regarding participation arises, the final decision will be made by the administration.
3. I understand that while on the field trip, student must remain with the group at all times. Written requests for alternative arrangements will be considered, but must be approved in advance of the trip.
4. Students must at all times abide by Johnson City Schools System's Code of Conduct, the Science Hill High School handbook for students and parents and the regulations of the teacher.
5. Emergency medications and physician orders currently at school may accompany student (ex. Epi-pen, diabetic kit).

Does student have the following?

Asthma: No ( ) Yes ( )
Inhaler will be needed and provided by parent/guardian to use on field trip? No ( ) Yes ( )
Instructions: _____

Severe Bee Sting Allergy: No ( ) Yes ( )
Epi-Pen and Benadryl will be needed and provided by parent/guardian to use on field trip? No ( ) Yes ( )
Instructions: _____

Diabetes: No ( ) Yes ( )
Insulin will be given at school by injection ( ) self ( ) or he/she is self dependent with Insulin Pump.
Instructions: _____

Food Allergy: No ( ) Yes ( ) Please list: _____
Epi-Pen and Benadryl will be given and provided by parent/guardian to use on field trip? No ( ) Yes ( )
Instructions: _____

Seizure Disorder: No ( ) Yes ( )
Medication given at home ( ) on Field Trip ( )
Instructions: _____

Medication Allergy: No ( ) Yes ( ) Please list: _____
Instructions: _____

Other Medical Condition(s): No ( ) Yes ( ) Please list: _____
Instructions: _____

Other Comments: _____

( ) I have read and agree to the above condition and hereby give my permission for my child to attend the listed field trip.

My child may receive emergency care and I agree to assume all expenses for moving and medical treatment. I consent to any treatment, surgery, diagnostic procedure, or the administration of anesthesia as may be necessary by the physician. (Life threatening situations only)

_____ _____
Parent/Guardian Signature Date

(3)

JOHNSON CITY SCHOOLS
HEALTH SERVICES
PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS

(Only for Grades 7th-12th)

Student's name: _____ Date of birth: _____

Check School: ❑ Liberty Bell Middle School ❑ Science Hill High School Grade: _____ School Year: _____

PLEASE CHECK ONE:

❑ **My Student is not allergic to any medications**

❑ **My Student IS ALLERGIC to the following medications:** _____

_____

List all medication your child takes on a routine basis:

Name of Medication	Dosage	Time to be taken	Purpose

List below any additional health information that the staff should be aware of: _____

_____

Please check **ALL** the boxes below of the over the counter medication that your child **MAY HAVE** during the school day. **PARENTS MUST PROVIDE THE OVER THE COUNTER MEDICATION CHECKED BELOW IN A NEW, UNOPENED BOTTLE OR IN A BLISTER PACK THAT IS SEALED AND LABELED.** Please list the symptoms (You may state "as needed" or choose to give specific symptoms) for which each medication is given.

Check	Medication	Symptoms for which medication may be used
	Acetaminophen (Tylenol)	
	Ibuprofen (Advil)	
	Antibiotic Ointment	
	Hydrocortisone Ointment (anti-itch)	
	Anti-acid	
	Benadryl	

I, the undersigned parent/guardian hereby give permission to Johnson City Schools Staff to administer the checked medications according to the manufacturer's recommendations to my child. I will notify the school nurse of any medications that are given prior to their arrival at school. I also release the Johnson City School System and its personnel from any legal claim they now have or may thereafter have arising from the administration of or failure to administer medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of medications.

Custodial Parent/Guardian Signature _____ Date: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Expired Medication cannot be given at school. We do not administer any medications containing SALICYLATE (such as Aspirin and Pepto-Bismol) due to the danger of REYE'S SYNDROME without a written physician's signature. If you have questions, please contact the Office of Health Services at 423-232-5380.

Form Updated 04/2018

(9)

FOR PHYSICIAN USE ONLY

- According to TN state law TCA 49-5-415 Students may carry and self-administer a prescribed asthma reliever inhaler under the following circumstances: the physician must provide the name, purpose, dose of medication, and the time(s) or special circumstances for use. The physician must further document that the student has been trained in the proper use of the inhaler.
- Physician signature indicates agreement with the plan and an order in good standing for the current school year.

_____ _____ may carry and self-administer the following metered dose asthma reliever medication by inhaler:
Name of student Date of birth

Name of Medication: _____

Purpose of Medication: _____

Time(s) or Circumstances when inhaler may be used: _____

_____

This student has been trained by a medical professional to independently use the metered dose inhaler: ☐ YES ☐ NO

Number of puffs allowed: _____

_____ _____ _____
Physician's Signature Date Phone

****Treatments, academic modification or activity restrictions will require separate written orders from the student's physician.**

I acknowledge that the school shall incur no liability and I indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the inhaler and my signature also indicates permission to notify staff of my student's individual health plan. I also give permission for the nursing department to contact my child's health care provider to obtain information or clarification regarding his/her medical condition. This consent form is binding for the entire school year unless I provide the school nurse with a written revocation.

_____ _____
Parent/Guardian Signature Date

If you have questions, please contact the Office of Health Services at 423-232-5380.

Form Reviewed 5/2019

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JOHNSON CITY SCHOOLS
HEALTH SERVICES
PARENTAL AUTHORIZATION FOR STUDENT TO CARRY/SELF-MEDICATE PRESCRIBED ANTIHISTAMINE AND EPINEPHRINE

Student's name: _____ Date of birth: _____

School: _____ Teacher: _____ Grade: _____ School Year: _____

List type and dose of antihistamine: _____

List type and dose of epinephrine: _____

Please check where the medicine will be kept:

- ❑ Student's Locker
- ❑ In student's backpack/purse
- ❑ Other – Please state location: _____

I understand that the Johnson City Schools System shall not be held responsible or liable for the administration of the above listed medication. The parent/guardian releases the school district and its employees and agents from liability for any injury that may result from the student's self-administration of medication. It is the responsibility of the parent/guardian to make sure the child carries the medication on a daily basis as well as on field trips and other off campus activities. If is further understood that the authorizing physician has given proper instruction in the use of the above listed medication(s) to the parent and the student. The privilege of self-administering may be withdrawn if the medication is not used in the proper manner or is left unattended.

_____ _____
Parent/Guardian Signature Date

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

********** TO BE COMPLETED BY STUDENT'S HEALTHCARE PROVIDER **********

Student's name: _____ Date of birth: _____

I certify this child has a health condition requiring the use of antihistamine and/or epinephrine. The parent/guardian and child have been instructed on how to properly administer this medication and are competent to manage dosing and administration.

Name of Medication(s)	Dosage	Route/Frequency

Length of time medication is required: ❑ Entire School Year ❑ _____ Number of weeks

_____ _____ _____
Physician's Signature Date Phone

PLEASE HAVE YOUR CHILD'S DOCTOR COMPLETE THE NEXT SECTION IF YOUR STUDENT IS GOING TO CARRY AND SELF-ADMINISTER THE INHALER

Form Reviewed 5/2019

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PL

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

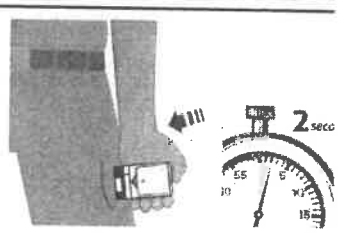
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PL

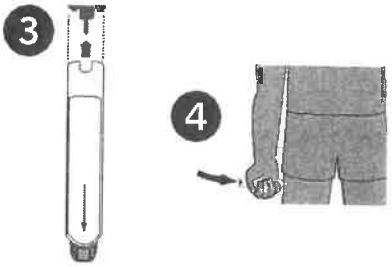
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



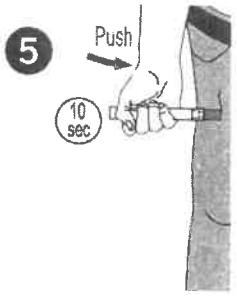
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



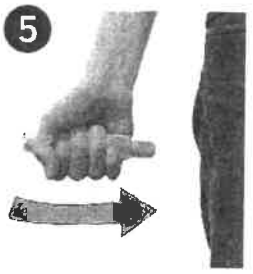
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

JOHNSON CITY SCHOOLS
HEALTH SERVICES
PERMISSION FOR MEDICATION ADMINISTRATION

(Prescription and Non-Prescription)

Many children and adolescents require medication to maintain an optimal level of functioning at school. While we encourage parents to give medication(s) at home, we understand that in some situations medication must be given at school. Medications must be brought to school by the parent/guardian in the original container with this signed permission form attached. The first dose or administration of any medication should be given at home. Expired Medication cannot be given at school. We do not administer any medications containing SALICYLATE (such as Aspirin and Pepto-Bismol) due to the danger of REYE'S SYNDROME without a written physician's signature. If you have questions, please contact the Office of Health Services at 423-232-5380.

Student's name: _____ Date of birth: _____

School: _____ Teacher: _____ Grade: _____ School Year: _____

Allergies: _____

Name of medication: _____ Strength: _____ Dosage: _____

Route of administration (by mouth, topical, inhalation, etc.): _____

Please check one: ❑ As Needed ❑ Daily (Time of day to given: _____)

Date started: _____ Date to be discontinued: _____

Purpose of medication: _____

Possible side effects: _____

Special Instructions: _____

_____

_____ ***IS*** competent to self-administer his/her medication with the assistance of trained school personnel.
(Student's Name)

_____ ***IS*** NOT competent to self-administer his/her medication and will require medication to be administered by the school nurse/trained school personnel or parent.
(Student's Name)

I give permission for personnel of Johnson City Schools to contact prescribing healthcare provider in the event there are questions about the medication(s). The health care provider has my permission to discuss the medication, diagnosis, side effects, etc. with Johnson City Schools personnel.

Unless otherwise specified, the duration of this consent will be for the entire school year. It is the responsibility of the parent/guardian to remove any unused medication from the school within 7 days of the last day of scheduled administration or the medication will be discarded by the school nurse. NO MEDICATION WILL BE SENT HOME BY STUDENTS.

Custodial Parent/Guardian Signature _____ Date: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
(Required for all medications – Prescription and Non-Prescription)

Emergency Contact: _____ Phone: _____

Physician Signature: _____ Date: _____ Phone: _____
(Required for all Prescription Medication and Non-Prescription Medication that will be administered on a regular basis longer than a four week period)

Form Updated 04/2018

(Enclosure B)

Cadet / Cadre
In-Processing Folder Checklist

Have the following items in the folders in order:

1. BSA Health Record (Physical form) (All) Encl. D
2. Cadet Information (All) Encl. E
3. Cadre Information Form Encl. F
4. Chaperone Contract Encl. G
5. Chaperone Information Encl. H
6. Consent for Medical Treatment (All) Encl. I
7. Covenant not to sue (All) Encl. J

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ **None**

_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, **I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met.** The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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680-001
2019 Printing

Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date:** **Insulin pump: Yes** ☐ **No** ☐
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/ heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma/reactive airway disease	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ Check here if no medications are routinely taken. ☐ If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature — MD/DO, NP, or PA signature (if your state requires signature)

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/mumps/rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		Exemption to immunizations **(form required)**	

Please list any additional information about your medical history:

_____

_____

_____

_____

DO NOT WRITE IN THIS BOX.
Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

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2019 Printing

Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin issues	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Has no uncontrolled heart disease, lung disease, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

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(Enclosure E) p. 1 of 2

CADET INFORMATION

STATEMENT REQUIRED BY PRIVACY ACT OF 1974

1. **AUTHORITY**: Title 10, U.S. Code 2102

2. **PRINCIPAL PURPOSE(S)**: To gather information, emergency points of contact, and statement of the physical condition of JROTC cadets attending JCLC.

3. **ROUTINE USES**: Normal Personnel Actions - Disclosures of information may be provided to proper authorities in actions regarding medical treatment, legal actions, investigation of accidents, preparation of statistics and training records resulting from annual JCLC.

4. **MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDIDNG INFORMATION**: Disclosure is voluntary. Failure of cadet to complete form will disqualify JROTC cadet from participating in annual JCLC.

1. **Cadet**:

_____
(Last Name, First, MI)

2. _____
(Name of School)

3. I will attend annual JCLC from _____ to _____ at Camp Davy Crockett.

4. **Parent or Guardian**

_____
(Name and Address)

5. Telephone: _____ Other: _____

6. **Family Doctor:**

_____
(Name and Address)

7. Telephone: _____ Other: _____

8. **Dentist**:

_____
(Name and Address)

9. Telephone: _____ Other: _____

(Enclosure E) p. 2 of 2

NOTE: IF PARENT OR GUARDIAN CANNOT BE CONTACTED, PLEASE LIST ONE OTHER PERSON TO CONTACT IN CASE OF AN EMERGENCY.

10. **Emergency Contact (other than parent)**:

_____
(Name and Address)

11. Telephone: _____ Other: _____

STATE OF PHYSICAL CONDITION

To the best of my knowledge, my son/daughter/ward is in good physical condition. Participation in the JROTC annual camp, in my opinion, will not have an adverse effect on his/her health and well-being. I will inform the JROTC Instructor and the JCLC Commander of any changes.

(_____)
Initials

My son/daughter/ward has a history of (identify illnesses or any other ailments) _____ _____, and is on _____ _____ medication. He/she is allergic to the following medication: _____.

NOTE: Students that are found to have previous history of any type illness, past injury, and/or symptoms of suspected medical aliment, will be returned home if treatment is needed or desired.

DENTAL RECORDS

I acknowledge my dental records contain detail profiles and/or x-rays of sufficient detail for identification.

Cadet (does) (does not) have a dentist or dental records.

_____ _____
(Print Parent/Guardian) (Signature of Parent/Guardian)

Date: _____

(Enclosure F)

CADRE INFORMATION FORM

STATEMENT REQUIRED BY PRIVACY ACT OF 1974

1. **AUTHORITY**: Title 10, U.S. Code 2102

2. **PRINCIPAL PURPOSE(S)**: To gather information, emergency points of contact, and statement of the physical condition of JROTC cadre and chaperones attending JCLC.

3. **ROUTINE USES**: Normal Personnel Actions - Disclosures of information may be provided to proper authorities in actions regarding medical treatment, legal actions, investigation of accidents, preparation of statistics and training records resulting from annual JCLC.

4. **MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDIDNG INFORMATION**: Disclosure is mandatory. Failure of cadre to complete form will disqualify them from participating in the annual JCLC.

1. **Cadre:**

_____
(Last Name, First, MI)

2. _____
(Name of School)

3. **Emergency Contact Person:**

_____ Relationship: _____
(Name and Address)

Telephone: _____ Other: _____

5. **Family Doctor:**

_____
(Name and Address)

6. **Telephone**: _____ Other: _____

(Enclosure G) **JCLC- 2020**

CHAPERONE CONTRACT

1. I agree to perform all duties as a chaperone as directed by the JCLC commandant and the BSA.

2. I understand that chaperones are on duty 24 hours/day for the duration of the JCLC.

(All Chaperones must complete the BSA Youth Protection Training and Bring their Certificate to camp with them)

3. Chaperones are expected to assist the cadre and enforce rules and regulations. Chaperones are not expected to perform as cadre, but will be included in meetings and in the dissemination of information.

4. I will encourage females to participate in all training events. I may, at my own request, participate in any training event.

5. JCLC will provide chaperones with lodging arrangements. Each school / Brigade will be responsible for expenses / travel/ transportation of their chaperone.

6. I understand that without the participation and cooperation of chaperone volunteers, some cadets would not be allowed the opportunity to attend JCLC.

7. I understand that female / male cadets will be under the supervision of a chaperone at ALL TIMES - 24 hours a day during JCLC.

_____ _____

(Chaperone Signature) **(JROTC Instructor Signature)**

_____ _____

(Chaperone Name Printed) **(Printed Name)**

_____ _____

(Date) **(Date)**

_____

(Principal's Printed Name, Signature and Date)

(Enclosure H)

CHAPERONE INFORMATION

NAME OF HIGH SCHOOL: _____

HIGH SCHOOL ADDRESS: (STREET): _____

(CITY): _____

(STATE & ZIP CODE): _____

(TELEPHONE #): _____

CHAPERONE INFORMATION

NAME OF CHAPERONE:

_____

(PRINT): (LAST) (FIRST) (MI)

CHAPERONE ADDRESS: (STREET): _____

(CITY): _____

(STATE & ZIP CODE): _____

(TELPHONE #): _____ AGE: _____

Contact Person at Home in case of emergency:

_____Phone: _____

Relationship: _____

Medical Issues:

_____

_____

_____

(SAI/AI SIGNATURE) _____

(Enclosure I)

CONSENT TO MEDICAL TREATMENT
(All Participants Cadre/Chaperone/Cadets)

STATEMENT REQUIRED BY PRIVACY ACT OF 1974

(1) AUTHORITY: TITLE 10, U.S. CODE 2102.

(2) PRINCIPAL PURPOSES: A statement authorizing medical care in civilian or government medical facilities while attending or traveling to or from JROTC annual JCLC.

(3) ROUTINE USES: Normal personnel actions: Disclosure of information may be provided to proper authorities in actions regarding medical treatment, legal actions as a result of injury or death, and investigation of accident resulting from JROTC annual JCLC.

(4) MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION: Voluntary. Failure to complete form will disqualify JROTC cadet from participating in specific voluntary training exercises.

I _____, consent to be treated in an Army Hospital, or any other government or civilian medical facility, near or in-route to Camp Davy Crockett, near Rogersville, TN while attending or traveling to or from JROTC annual JCLC from _____ to _____.
(Date) (Date)

This consent encompasses all procedures and treatments as are found to be necessary or desirable, in the judgment of the professional staff of any of the above-named medical facilities. I understand that this consent is of a general nature and accordingly list the following exceptions to this consent (if no exceptions write "No Exceptions")

I (am) (am not) on medication. (List type on back, if on medication)
I (am) (am not) allergic to medication. (List type on back, if allergic)
It is understood that this consent can be withdrawn in writing or orally at any time.

_____ _____
Signature of Witness Signature of Cadet

_____ _____ SSN _____
Print Name of Witness Print Name of Cadet

PARENT OR GUARDIAN: (When cadet is a minor or unable to give consent), I _____, parent/guardian of _____ have read and understood the above consent to treatment and hereby expressly consent to the above-described treatment.

_____ _____
Signature of Witness Signature of Parent

_____ _____ Last 4 SSN _____
Print Name of Witness Print Name of Parent

(Enclosure J)

COVENANT NOT TO SUE

OFF-CAMPUS TRAINING AND PRACTICAL FIELD/HIGH RISK TRAINING

(1) AUTHORITY: Title 10, U.S. Code 23-1.

(2) PRINCIPAL PURPOSE(S): To release the U.S. Government, the host institution and the state in which said institution is located from liability for injury; death, or damages for JROTC cadets participating in voluntary off-campus training programs, practical field, and high-risk training.

(3) ROUTINE USES: Normal personnel actions. Disclosures of information may be provided to proper authorities in actions regarding law enforcement, legal actions as a result of injury or death, and investigations of accidents resulting from such voluntary off-campus training, practical field, and high-risk training.

(4) MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION: Voluntary. Failure to complete form will disqualify JROTC cadets from participating in specific voluntary training exercises.

I_____, residing at_____,
(Type or print full name) (Address) (City)

do hereby agree that in consideration for being allowed to participate in JROTC Cadet Leadership Challenge conducted by Camp Davy Crockett and the Army JROTC program from

_____high school, an Army and BSA supervised activity, and whereas I am
(Name of School)

doing so entirely on my own initiative, risk, and responsibility; and being fully aware of the risk adhering to this type of training, I hereby RELEASE AND DISCHAGE FOREVER, the United States Army, Boy Scouts of America, the JROTC unit, the State of _____ and Tennessee and all of its officers, agents, and employees, acting officially from any and all claims, demands, actions or causes of action, on account of myself OR on account of any injury to me which may occur from any cause during said activity or continuances thereof, and I do further covenant and agree to hold the said Government of the United States, State of _____, and all of its officers, agents, and employees, acting officially or otherwise, blameless for any and all damages which I may cause either intentionally or thru my negligence.

_____ _____
Typed/Printed Name of Parent or Guardian Signature of Parent or Guardian

_____ _____
Relationship to Cadet Date

WITNESSED BY: _____ Age/_____

Period Covered_____ Signature of Cadet_____ Date_____

Packing List for JCLC

Aqua Shoes	1 Pair
OCP Cap *	1 each
OCPs *	3 Sets
OCP Belt *	1 Each
Boots, OCP *	1 Pair
Boot Scrub Brush	1 Each
Blanket/Sleeping Bag	1 Each
Bras	4 Each (Recommend Sports Bras as Well)
Canteen w/cup and cover *	2 Each
Canteen 2 QT W/ Cover	1 Each
Clothes Hangers	6-10 each
Duffle Bag *	1 Each
Flashlight/ Batteries	1 Eaxh
Padlocks	1 Each
Poncho *	1 Each
Pistol Belt *	1 Each
PT Uniform	1 Set (shoes, shorts, T-shirt)
Shower Shoes	1 Set (flip flops, etc)
Socks, Boot *	6 Pair
Socks, White	5 Pair
Swim Suit W/Tshirt	1 Each (**Girls Must Wear a 1 Piece**)
Tennis Shoes	1 Pair
Towels, Bath	2 Each Minimum
T-Shirts, OCPs *	4 Each
Underwear	5 Each
Washcloth	1 Each
WW Top*	1 Each
Writing Material	

*** Items to be Issued by JROTC Department**

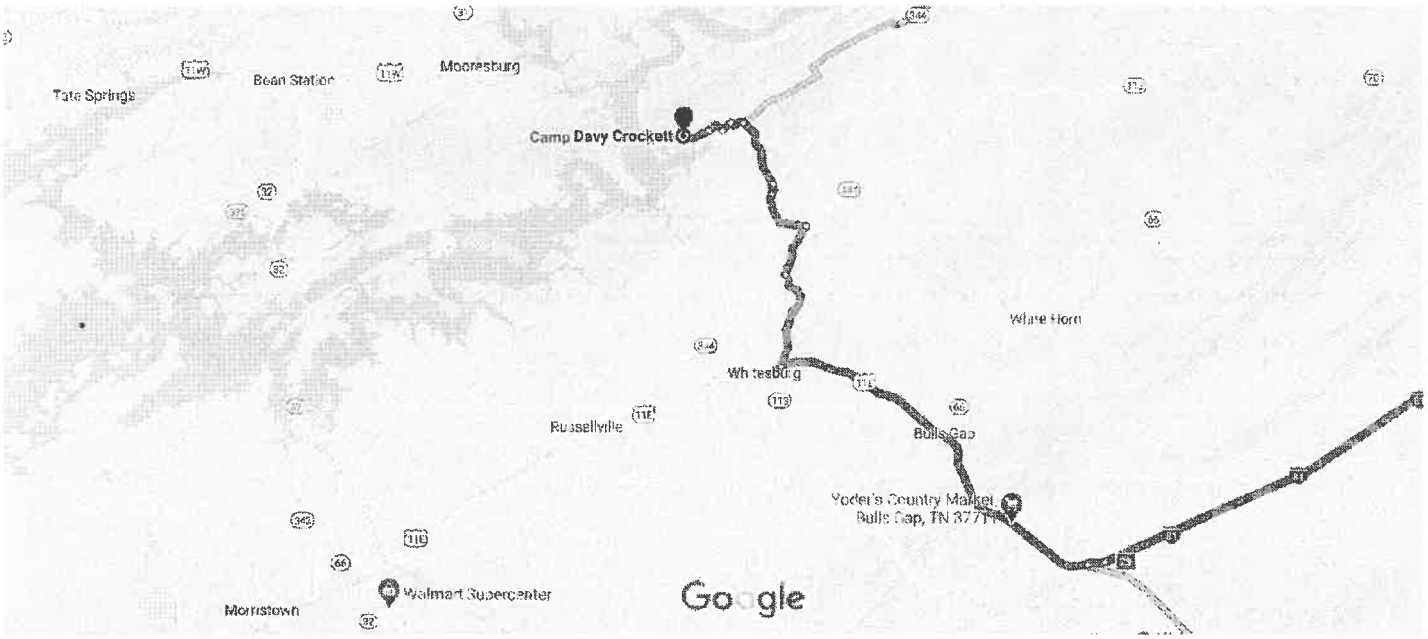
Optional Items
Camera
Cell Phone (Not in Training Area)
Pajamas/Robe
Personal Clothing for Non-Training Times
Pillow

Prohibited Items
Alcohol Items
Electronics
Tobacco of Any Kind
Fire Arms

Words of Advice: Don't Bring Anything You Can't Afford to Lose.
Personal Items: toothbrush and paste, comb/hair brush, razor, shaving cream, deodorant, soap with dish, foot powder, chap stick, Vaseline, sun screen, insect repellent, etc.

Boot Break-In: Cadet must wear their boots regularly prior to camp in order to "break them in". Ensure the boots fit properly. Use powder to keep feet dry, use moleskin or appropriate bandage on injured skin, etc.

Google Maps **Your location to Camp Davy Crockett** Drive 62.1 miles, 1 h 11 min



Map data ©2020 2 mi

Your location

Get on I-26 W/US-23 N from E 10th Ave, Welbourne St, E 8th Ave and Baxter St

5 min (1.2 mi)

1. Head west on Oak Street Extension toward E 10th Ave

456 ft

2. Turn left onto E 10th Ave

469 ft

3. Turn right to stay on E 10th Ave

292 ft

4. Turn left at the 1st cross street onto Welbourne St

0.2 mi

5. Turn left onto E 8th Ave

0.3 mi

6. Turn right at the 3rd cross street onto Baxter St

0.2 mi

7. Turn right onto E Unaka Ave

466 ft

8. Turn right at the 1st cross street onto Oak St

92 ft

- Recomend use GPS as some street signs are missing or difficult to read.

- ~~The~~ 423-235-4918 This is the phone number to the office. This number is for emergency use only.

9. Take the Interstate 26 W/U.S. 23 N ramp on the left

0.2 mi

Follow I-26 W/US-23 N and I-81 S to US-11E S in Mosheim. Take exit 23 from I-81 S

43 min (47.9 mi)

10. Merge onto I-26 W/US-23 N

13.7 mi

11. Take exit 8A to merge onto I-81 S toward Knoxville

33.9 mi

12. Take exit 23 for US-11E toward Greeneville/Bulls Gap

0.3 mi

Continue on US-11E S. Take TN-113 N to Lee Valley Rd in Hamblen County

23 min (13.0 mi)

13. Turn right onto US-11E S (signs for Bulls Gap)

6.7 mi

14. Turn right onto TN-113 N

1.8 mi

15. Turn right onto TN-113 N/TN-344 N

0.9 mi

16. Turn left onto Thompson Rd

1.0 mi

17. Slight right onto Grassy Valley Rd

0.2 mi

18. Turn left onto Ninny Ridge Rd

1.2 mi

19. Turn left onto Bingham Rd

0.3 mi

20. Turn left onto Scout Camp Rd

0.2 mi

21. Turn right

0.3 mi

22. Continue onto Lee Valley Rd

Destination will be on the right

0.5 mi

Camp Davy Crockett

142 Scout Camp Rd, Whitesburg, TN 37891