

Tamarac Fire Rescue

Cadet Program Application & Contacts

Please complete the following application clearly and legibly in blue or black ink. This application form must be turned in with the attached hold harmless agreement and media release form, signed and notarized.

Applicant Name		Applicant Phone Number	
Address			
City		State	Zip
Sex	D.O.B.		Current Age
School Name		Current Grade	
EMERGENCY CONTACT INFORMATION			
Parent/Guardian Name		Relationship	
Phone Number (Home)		Alt. Phone Number (Cell)	
Cell Phone Carrier	Email Address		
Parent/Guardian Name		Relationship	
Phone Number (Home)		Alt. Phone Number (Cell)	
Cell Phone Carrier	Email Address		
Doctor's Name		Doctor's Phone Number	
List Any Known Allergies			
Additional Medical Information (if applicable)			
Parent/Guardian Signature		Date	
Cadet Applicant Signature		Date	

Cadet Media Release

The media release for anyone under the age of 18 must include the signature of a parent or guardian!

I hereby grant the Tamarac Fire Rescue Department the right to obtain and/or use my child's photograph, digitized image, and video for media release and/or educational purposes.

I understand that such media and all subsequent uses of that media, including publications, presentations, web sites, videos, and multimedia productions become the property of the Tamarac Fire Rescue department and may be disseminated to the public via appropriate media channels.

I understand that a photograph of my child appearing on the approved City of Tamarac home pages on the World Wide Web will not identify my child by name.

This Release is For (Name)	Program Name Tamarac Fire Rescue Cadet Program
Parent/Guardian Name (Please print)	
Signature of Parent/Guardian	Date

I **do not** authorize the use of my child's photograph, digitized image, and video for media release and/or educational purposes.

This Release is For (Name)	Program Name Tamarac Fire Rescue Cadet Program
Parent/Guardian Name (Please print)	
Signature of Parent/Guardian	Date

State of Florida County of _____	<u>Notary Seal/Stamp below</u>
This document was signed before me this ____ day of _____, 20____. by _____.	
My commission expires: _____ Notary Signature: _____	

Cadet Requirements List

Prospective Cadet applicants must complete the Full application before their initial meeting with the Cadet Program manager which includes the following documentation:

- Application & Contacts Form
- Hold Harmless Agreement
- Media Release (signed and notarized)
- Birth certificate copy
- Driver's License or photo ID of prospective candidate and parent/guardian
- Current health certificate from a medical doctor allowing program participation
- Report Card copy and proof of current GPA
- Essay Requirement:
In a one page essay explain why you would like to join the Cadet Program and what you believe your involvement will bring to the group

The following items are the responsibility of the Cadet and parent/guardian after acceptance into the program. These items can be purchased at the Army Navy Outdoors store at 1707 State Road 7 in North Lauderdale.

- Black Tru spec BDU Pants (24/7)
- Magnum Boots (zipper preferred)
- Black Belt

The Tamarac Fire Rescue Cadet Program Management will provide each new Cadet member with the following items:

- Program T Shirt (1 replacement)
- Program Polo Shirt (1 replacement)
- Helmet (replacement at market value)
- Bunker Jacket (replacement at market value)
- Bunker Pants (replacement at market value)
- Boots (replacement at market value)
- Gloves (1 replacement)

If any of the above listed items are lost, stolen, or damaged beyond repair it is the responsibility of the Cadet and their parent/guardian to replace it at market value.

Please sign below acknowledging that you agree to the terms listed above:

Participant Signature	Date
Parent/Guardian Signature	Date



TAMARAC FIRE RESCUE

Cadet Program Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child’s Medical History.

(Please Print)

Name of Child (Last, First)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First)	

PART I — CHILD’S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.

(Please explain any “Yes” answers in the space provided below.)

1. Yes No Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes No Any other specific illness or social/emotional or behavioral problems?
3. Yes No Any allergies (food, insects, medication, etc.)?
4. Yes No Any prescription medication (daily or occasionally)?
5. Yes No Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes No Any hospitalization, operation, or major illness (specify problem)?
7. Yes No Any significant injury or accident (specify problem)?

To Parent/Guardian: Please explain any “Yes” answers from above.

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this program and any cadet program health personnel providing services in the district for the limited purpose of meeting my child’s health and educational needs.

⊗ _____
Signature of Parent/Guardian

Date



Name of Child (Last, First, Middle)	Birth Date
-------------------------------------	------------

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: _____
 (Exam must be performed before applicant interview) Month Day Year

Screening Results:
 Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>	Hearing – Right	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>
Vision - With Glasses	Right 20/_____	Left 20/_____	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>		Hearing – Left	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>	Referred <input type="checkbox"/>

- Gross dental (teeth and gums) Normal Abnormal _____ Refer/Tx: _____
- Head/scalp/skin Normal Abnormal _____ Refer/Tx: _____
- Eyes/Ears/Nose/Throat Normal Abnormal _____ Refer/Tx: _____
- Chest/Lungs/Heart Normal Abnormal _____ Refer/Tx: _____
- Abdomen Normal Abnormal _____ Refer/Tx: _____
- Postural assessment Normal Abnormal _____ Refer/Tx: _____

TB risk assessment done

This child has the following problems that may impact the educational experience:

- Vision Hearing Speech/Language Physical Social/Behavioral Cognitive

Specify: _____

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

- This child may participate fully in program activities including physical exercises.
- This child may participate in program activities including physical exercises with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
<input type="checkbox"/>	____/____/____	
Name (Please print or stamp)		