Standard Activity and Training Form

(For use when attending multi-unit events or higher HQ events)

Event: _____ Div: ____ Unit: _____

A. Young Marine Information

Last Name: _____ First Name: _____ M.I. _____

Age: ____ Date of Birth: _____ Gender: _____ Date of H.S. Graduation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone number: _____

B. Parent/Guardian Information

Parent/Guardian Name: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Cell Phone Number: _____ Work Number: _____

C. Emergency Contact Information (other than parent/guardian)

In the event I cannot be reached during an emergency please contact the following person:

Emergency contact name: _____ Relationship: _____

Email Address: _____ Phone Number: _____

Cell Phone Number: _____ Work Number: _____

D. Permission of attendance

_____ has my permission to attend _____.

Young Marine's name Event

Location: _____

Dates of event: _____

X Parent/Guardian Signature: _____ Date: _____

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E. Photo/Video/ Film Release

____ I give my consent to authorize the Young Marines National Headquarters or any entity or person designated by them use and reproduction of any and all photographs, video or film taken of the person named above during the program training activities and related activities. I understand there will be no compensation to me. All negatives and positives with said prints, video or film are the property of the Young Marines National Headquarters or the entity or person authorized or designated by it, solely and completely. I also waive any right to inspect or approve any photo, video or film taken during my visit. I affirmatively release and or otherwise, of photos video, or film taken of me during this event.

____ I do not give my consent.

X _____ X _____

Signature of attendee Signature of Parent/Guardian

F. Medical Consent

I certify that I am the parent, legal guardian or other person in legal control of the above identified child and request that my child be administered appropriate first aid and/or taken to the nearest medical facility for emergency treatment as necessary.

X Parent/Legal Guardian: _____ Date: _____

G. Permission to Use Over-the-Counter Medication (*if not completed the Young Marine will not receive medication*)

My child, _____, has my permission to take any over-the-counter medication in accordance with label instructions as needed with the exception of: _____ _____ while attending Young Marine Activities.

X Parent/Legal Guardian: _____ Date: _____

H. Permission to Dispense Prescription Medication (*If not completed the Young Marine will not receive medication)*

I, request and authorize that my child, _____, be administered the following prescription medication(s) _____ _____

per the medical doctor's instruction on the original and unexpired pharmacy label. I certify that my child has a valid health reason for taking the medication during Young Marine activities. This permission form is valid from (beginning date) _____to (ending date) _____.

X Parent/Legal Guardian: _____ Date: _____

I. Medical Insurance Information

Name of Medical Insurance Company: _____

Policy Number: _____ Group Number: _____

Contact telephone number: _____

Must provide a copy of front & back of medical card.

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Health History (Completed by Parent/Legal Guardian)

PLEASE PRINT (Update Annually)

Note: For the safety and well being of your child ensure all information is true and correct. Your child will NOT be disqualified from the program based on information provided here.

Last Name _____First Name _____Middle Initial____

Age _____ Date of Birth ___/____/____ Social Security Number_____

Parent/Guardian Name _____

Home Number (____)_____ Work Number (____)_____

Physician's Name _____Date of Last Visit _____

Dentist's Name _____Date of Last Visit _____

The Subject Young Marine:	***Yes**	**No**	**Remarks ("Yes" require remarks)**
Wears Eye Glasses /Contact Lenses			
Is on a restricted diet			
Wears a hearing aid			
Visited the Dentist in the last 6 months			
Has known health problems (knee problems, migraines, etc.)			
Is under a doctors care			
Is on prescription medication			
*Has Allergies Food//Medication//Environmental (pollen, bee stings)			
Has heart murmur Suffered Rheumatic Fever Had a family member under age 50 die of a heart problem			
Suffers one or more of the following conditions: Seizures, Diabetes, Asthma, Arthritis			
Has had a history of head injury			
Has been hospitalized or had surgery and dates			
Had injuries (no matter how minor) in the past year. (Sprains, broken bones, ingrown toenails, stitches)			
Date of last Tetanus Shot			

I certify the above to be complete, correct, and true to the best of my knowledge.

X Parent/Legal Guardian _____ Date _____

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Unit Commander's Endorsement

I have personally interviewed the applicant and reviewed the applicant's record. I attest that the applicant:

a. Is eligible and meets all of the qualification requirements for the selected program. ___.

b. Has taken the PFT on (mm/dd/yy) ____/____/____ and passed with an overall score of _____.

c. Has attained his/her present rank on (mm/dd/yy) ____/____/____.

I attest that:

d. I have enclosed one unit check (no. _____) in the amount of $_____.00 as part of the application fee (non-refundable), if applicable.

e. Below is a current photo of applicant.

_____ _____

Unit Commander's Signature *Date*

Daytime Telephone No. (____) _____

Attach
Young Marine's
Head & Shoulder
Photograph
in this box