
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, and preparation of statistics and training records resulting from JCLC.
 4. **MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION:** Disclosure is voluntary. Failure of cadet to complete form will disqualify JROTC cadet from participating in JCLC.
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1. **Cadet:** _____
(Last Name, First, MI)
2. _____
(Name of School)
3. I will attend JCLC during (X) First Cycle or () Second cycle
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: _____

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

10. **Emergency Contact:** _____
(Name and Address)

11. Telephone: _____ Other: _____

STATE OF PHYSICAL CONDITION

(_____) _____
Initials

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

(_____) _____
Initials

My son/daughter/ward has a history of (identify conditions such as heart disease, asthma, overweight, rheumatic fever, chronic ear infections, headaches, or any other ailments).

_____ ,

and is on _____ medication(s). He/she is allergic to the following medication(s): _____.

NOTE: Students that are found to have previous history of any type illness, past injury, and/or symptoms of suspected medical ailment, 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.

I (do) (do not) have a dentist or dental records.

(Signature of Cadet/Parent/Guardian)

(Signature of Cadet/Parent/Guardian)