

**NOTICE**

This form, used as a supplement to the Report of Medical History, is **MANDATORY** for all Cadets who are currently taking medication and will report to training with prescription and/or non-prescription (over the counter) medications. Cadets may bring prescription and non-prescription medication to training as long as the medication is not for a contagious illness or physical condition that would normally preclude his/her full participation in rigorous physical activity. Medication must NOT have expired. This form is to be used in conjunction with the current report of Medical History when screening cadets prior to attending "ALL" trainings for those taking medications.

**THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE.** If the cadet is taking prescription medications, a qualified medical provider must endorse this document in Section 10, confirming the accuracy of the prescription information provided. Medical provider signature for OTC medications is NOT REQUIRED; parent signature is sufficient for OTC medications.

Commanding Officers of Training Contingents (COTC) and Senior Escort Officers (SEO) retain the obligation and right to deny acceptance for training to any Cadet if upon review of the Report of Medical History and this document, it is determined that the Cadet is not physically and/or medically qualified (without ADA accommodation). This includes a determination that they do not have sufficient or qualified personnel to administer required medications. Parents/Legal Guardians should be consulted before making these type determinations.

**1. PERSONNEL INFORMATION**

<b>1a.</b> Last Name	<b>1b.</b> First Name	<b>1c.</b> MI	<b>1d.</b> USNSCC ID Number
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**2. TRAINING INFORMATION**

<b>2a.</b> Training Code	<b>2b.</b> Training Start Date	<b>2c.</b> Training End Date	<b>2d.</b> Training Days 0	<b>2d.</b> Training Location
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**3. PACKAGING AND LABELING REQUIREMENTS**

<b>3a. Prescription Medication</b> <ul style="list-style-type: none"> <li>Must be in the original container from the pharmacy or manufacturer.</li> <li>Must have a complete prescription label attached to the container.</li> <li>The container will only contain the medication it is labeled for.</li> <li>The Cadet must be the person prescribed the medication and his or her name must appear on the prescription label.</li> </ul>	<b>3b. Non-Prescription Medication (Over the Counter)</b> <ul style="list-style-type: none"> <li>Must be in the original container from the manufacturer.</li> <li>Must have a complete manufacturer's label attached to the container identifying the contents and directions for use.</li> <li>The container will only contain the medication it is labeled for.</li> </ul>
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**4. PRESCRIPTION OR NON-PRESCRIPTION MEDICATION** *(Use additional documents if more than three medications are provided)*

<b>4a.</b> Name of Medication	<b>4b.</b> Strength	<b>4c.</b> Total Quantity Required	<b>4d.</b> Total Quantity Sent
<b>4e.</b> Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	<b>4f.</b> Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 4i and/or Block 7		
<b>4g.</b> Prescribing Provider Name	<b>4h.</b> Prescribing Provider Phone Number	<b>4i.</b> Prescribing Provider Phone Number (alternate)	
<b>4j.</b> Reason for medication <i>(Describe in detail if necessary)</i>			
<b>4k.</b> Relevant side effects to be observed if any: <i>(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)</i>			
<b>4l.</b> List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
<b>4m.</b> Expected effects if medication is not taken as directed.			

**5. PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS** *(Use additional documents if more than three medications are provided)*

<b>5a.</b> Name of Medication	<b>5b.</b> Strength	<b>5c.</b> Total Quantity Required	<b>5d.</b> Total Quantity Sent
<b>5e.</b> Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:	<b>5f.</b> Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 5i and/or Block 7		
<b>5g.</b> Prescribing Provider Name	<b>5h.</b> Prescribing Provider Phone Number	<b>5i.</b> Prescribing Provider Phone Number (alternate)	
<b>5j.</b> Reason for medication <i>(Describe in detail if necessary)</i>			
<b>5k.</b> Relevant side effects to be observed if any: <i>(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)</i>			
<b>5l.</b> List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
<b>5m.</b> Expected effects if medication is not taken as directed.			

## MEDICAL HISTORY SUPPLEMENTAL

**6. PRESCRIPTION OR NON-PRESCRIPTION MEDICATION** *(Use additional documents if more than three medications are provided)*

<b>6a.</b> Name of Medication	<b>6b.</b> Strength	<b>6c.</b> Total Quantity Required	<b>6d.</b> Total Quantity Required
<b>6e.</b> Storage (Use Block 7, if necessary) <input type="checkbox"/> Refrigerate <input type="checkbox"/> Child-Proof Cap <input type="checkbox"/> Other:		<b>6f.</b> Frequency and Dosage (check one) <input type="checkbox"/> As needed, as labeled <input type="checkbox"/> On schedule, as labeled <input type="checkbox"/> Other: See Block 6l and/or Block 7	
<b>6g.</b> Prescribing Provider Name	<b>6h.</b> Prescribing Provider Phone Number	<b>6i.</b> Prescribing Provider Phone Number (alternate)	
<b>6j.</b> Reason for medication <i>(Describe in detail if necessary)</i>			
<b>6k.</b> Relevant side effects to be observed if any: <i>(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)</i>			
<b>6l.</b> List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.			
<b>6m.</b> Expected effects if medication is not taken as directed			

**7. REMARKS** (please include comments as required by Blocks 4, 5 and/or 6. Also provide any other medical history that you or your physician deems important)

<b>8. STATEMENT OF UNDERSTANDING AND CONSENT</b>	Parent/Guardian Initial Below
<b>8a.</b> During the NSCC/NLCC training evolution, NSCC medical personnel on duty and/or assigned NSCC staff members have my permission to administer the medication listed in Block 4, Block 5 and/or Block 6. I understand that all medications provided to the NSCC training contingent staff, must be in the original medication bottle containing all of the information required by Block 4, 5, and/or 6.	
<b>8b.</b> I give consent to the NSCC staff to contact the medical provider as needed for clarification with regard to medications listed and the conditions for which the medication is prescribed. The medical provider has been notified that the NSCC is authorized to obtain medical/prescription information if necessary.	
<b>8c.</b> I understand that all medications will be collected at the beginning of training and administered to the Cadet based on dosing instructions on the medication bottle/package. In no instance will Cadets be allowed to self-medicate with any medication whether it is over the counter or prescription. I understand I must provide the required amount of medication needed for the entire duration of the training evolution.	
<b>8d.</b> I understand that the Commanding Officer of the Training Contingent (COTC), and/or National Headquarters (NHQ) retains the authority to not accept and/or terminate Cadet's training at any time due to medical/other reasons. If terminated, parent agrees to immediately pick up their son/daughter upon notification by the COTC and/or training staff.	

**9. AUTHORIZATION AND RELEASE**

I certify that, to the best of my knowledge, the information provided is true and accurate and I have disclosed all pertinent medical history. Furthermore, I authorize the Naval Sea Cadet Corps, its agents, officials, and training staff members, to dispense medication listed on this authorization and I "Hold Harmless" the Naval Sea Cadet Corps from any and all liability, actions, or causes of action for damages or injury that may arise, directly or indirectly, from my child's use of medication while participating in Naval Sea Cadet Corps activities. I understand that training staff members may not be medical professionals and that medication will be dispensed according to the manufacturer's instructions and/or the instructions I provided on this authorization.

<b>9a.</b> Name of Parent/Guardian (Type or Print)	<b>9b.</b> Signature	<b>9c.</b> Date (DD MMM YY)
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**10. ENDORSEMENTS**

I have reviewed the medical record of this cadet and certify that the medications listed on this form are true and correct as prescribed and that this cadet is physically able to attend the listed training evolution.

<b>10a.</b> Name of Medical Provider (Type or Print)	<b>10b.</b> Signature	<b>10c.</b> Date (DD MMM YY)
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I certify that I have reviewed the above information and the Cadet listed on this form is physically able to attend the listed training evolution.

<b>10d.</b> Name of Commanding Officer (Type or Print)	<b>10e.</b> Signature	<b>10f.</b> Date (DD MMM YY)
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<b>U.S. NAVAL SEA CADET CORPS</b> <b>U.S. NAVY LEAGUE CADET CORPS</b>	<b>CADET APPLICATION</b> <b>REQUEST FOR ACCOMMODATION</b>	<i>FOR OFFICIAL USE ONLY</i>
<b>INSTRUCTIONS</b>		
Complete this form <u>ONLY</u> when an accommodation is requested for a prospective cadet under the Americans with Disabilities Act		
<b>1. UNIT INFORMATION</b>		
<b>1a. Unit Name</b> CBW PATHDINDERS DIVISION	<b>1b. Region</b> 021	<b>1c. Date of Request (DD MMM YY)</b>
<b>1d. Full Name and Rank of Commanding Officer</b>	<b>1e. Commanding Officer's Phone Number</b>	<b>1f. Commanding Officer Email Address</b>
<b>2. CADET INFORMATION</b>		
<b>2a. Last Name</b>	<b>2b. First Name</b>	<b>2c. MI</b>
<b>2d. Age</b>	<b>2e. Parent/Guardian Names(s)</b>	
<b>2f. Parent/Guardian(s) Phone Number</b>		<b>2g. Parent/Guardian(s) Email Address</b>
<b>3. ASSESSMENT (Completed by Parent/Guardian with assistance of the Unit Commanding Officer)</b>		
My Son/Daughter's disability is <i>(optional)</i> :		
<b>4. ACCOMMODATION</b>		
I am requesting the following accommodation for my son/daughter:		
<b>5. DETERMINATION</b>		
If Unit Commanding Officer determines accommodation is considered not reasonable, or cannot be made, Unit Commanding Officer must so state, with firm reasons and further forward to the Regional Director for review/comment and NHQ Representative for final determination. Reason for not approving is:		
<b>6. ACCOMMODATION PLAN</b>		
If Unit Commanding Officer agrees, the plan of accommodation based on individual assessment to allow enrollment and participation, agreed to by all parties, is (be specific as to can do's, and can't do's, limitations, escorting requirements, Recruit Trainings and advanced training, and alternate activities/events, etc. <i>Note: Plan can be modified/adjusted/refined at any time.</i> ):		

<b>REQUEST FOR ACCOMMODATION</b>		
<b>7. ENDORSEMENTS</b>		
<b>7a.</b> Full Name of Parent/Guardian (Print or Type)	<b>7b.</b> Signature	<b>7c.</b> Date (DD MMM YY)
<b>7d.</b> Full Name and Rank of Commanding Officer (Print or Type)	<b>7e.</b> Signature	<b>7f.</b> Date (DD MMM YY)
<b>FORWARD TO REGIONAL DIRECTOR FOR RECOMMENDATION</b>		
<b>8. REGIONAL DIRECTOR'S RECOMMENDATION:</b> <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove		
Reason for Disapproval or Recommended Modification:		
<b>8a.</b> Full Name and Rank of Regional Director (Print or Type)	<b>8b.</b> Signature	<b>8c.</b> Date (DD MMM YY)
<b>FORWARD TO NHQ REPRESENTATIVE FOR DECISION</b>		
<b>9. NHQ REPRESENTATIVE'S DECISION:</b> <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove		
Reason for Disapproval or Recommended Modification (if modification is recommended, request is returned to the Unit Commanding Officer for further negotiation with parent/guardian regarding the plan for accommodation)		
<b>NHQ Representative retains originals; return copy of decision to Unit CO, copy to Regional Director and National Headquarters.</b>		
<b>9a.</b> Full Name and Rank of NHQ Representative (Print or Type)	<b>9b.</b> Signature	<b>9c.</b> Date (DD MMM YY)
Complaints regarding the <b><u>NHQ Representative's Decision</u></b> to limit participation of a cadet in NSCC activities and/or the denial of a reasonable accommodation should be forwarded to:		
<p>Executive Director, Naval Sea Cadet Corps  2300 Wilson Blvd. Suite 200  Arlington, VA 22201-5435</p>		
Complaints regarding any final <b><u>NSCC NHQ Decision</u></b> to limit the participation of a cadet in NSCC activities and/or the denial of a reasonable accommodation should be forwarded to:		
<p>Assistant Secretary of the Navy (Manpower and Reserves)  Department of the Navy  1000 Army Navy Drive  Arlington, VA 20350-1000</p>		