MARINE CADETS OF IOWA (MCI)	CADET ENROLLMENT APPLICATION	*FOR OFFICIAL USE ONLY*

INSTRUCTIONS

1. Please print or type only with black or blue ink.
2. Fill in all blocks that apply; for those that do not, enter "Not Applicable" or "N/A"
3. Endorsement of all agreements and releases and remittance of fees is required to continue the enrollment process.
4. Parents and/or cadets are required to keep mailing addresses, email addresses, phone numbers, and medical information current with MCI.

1. APPLICANT INFORMATION

1a. Last Name	**1b.** First Name	**1c.** Middle Name	**1d.** Sex ☐ Male ☐ Female

1e. Home Address	**1f.** City	**1g.** State	**1h.** Zip Code + 4

1i. Date of Birth (DD MMM YY)	**1j.** Primary Phone	**1k.** E-Mail Address

1i. Full-time Student? ☐ Yes ☐ No *If yes grade:*	**1m.** School Name & City	**1n.** GPA

1o. Has the applicant ever been charged **OR** convicted of a criminal offense? Answering yes does not mean your cadet will not be able to enroll but this information is used to determine the appropriateness of the enrollment in this program. *(use an additional sheet if necessary)*

☐ Yes ☐ No *If yes please explain:*

1p. Citizenship ☐ U.S. Citizen ☐ Legal Resident - Registration Number:	**1q.** Referred/Recruited by (Cadet Name, if applicable)

2. APPLICANT PROMISE

I promise to serve faithfully, honor our flag, abide by Marine Cadets of Iowa Regulations, carry out the orders of the officers appointed over me, and so conduct myself as to be a credit to myself, my family, the Marine Cadets of Iowa, the United States Marine Corps, and my country. So help me God. Semper Fidelis!

2a. Applicant Signature	**2b.** Date (DD MMM YY)

3. PRIMARY PARENT/LEGAL GUARDIAN INFORMATION *(will be listed as next of kin and first contact in case of an emergency)*

3a. Name	**3b.** Relationship ☐ Mother ☐ Father ☐ Guardian ☐ Other:

3c. Address	**3d.** City	**3e.** State	**3f.** Zip Code + 4

3g. Primary Phone	**3h.** Alternate Phone	**3i.** E-Mail Address

4. SECONDARY PARENT/LEGAL GUARDIAN CONTACT INFORMATION

4a. Name	**4b.** Relationship ☐ Mother ☐ Father ☐ Guardian ☐ Other:

4c. Address	**4d.** City	**4e.** State	**4f.** Zip Code + 4

4g. Primary Phone	**4h.** Alternate Phone	**4i.** E-Mail Address

5. EMERGENCY CONTACT INFORMATION (*will be contacted in case primary or secondary contacts are unreachable in case of an emergency*)

5a. Name	**5b.** Relationship ☐ Grandparent ☐ Other Relative ☐ Family Friend

5c. Address	**5d.** City	**5e.** State	**5f.** Zip Code + 4

5g. Primary Phone	**5h.** Alternate Phone	**5i.** E-Mail Address

6. DEMOGRAPHICS (this information is gathered for potential federal grant purposes and is only reported in the aggregate)

6a. Ethnicity

☐ White (Non-Hispanic) ☐ Black (Non-Hispanic) ☐ Hispanic ☐ Asian ☐ Native American/Alaskan Eskimo ☐ Pacific Islander ☐ Other ☐ Decline to State

6b. Community Profile

☐ Inner City ☐ Urban ☐ Suburban ☐ Rural ☐ Other ☐ Decline to State

PREVIOUS EDITIONS ARE OBSOLETE

CONSENT AND RELEASE OF LIABILITY BY PARENT/GUARDIAN

8. PARENT/LEGAL GUARDIAN AGREEMENT & CONFIRMATION

I hereby consent to my child/ward enrolling in the Marine Cadets of Iowa (referenced as MCI). I understand that the MCI is organized along military lines, that MCI regulations govern my child's/ward's membership, and that violation of said regulations may result in my child's/ward's discharge from MCI. I will ensure that my child/ward abides by all regulations and lawful orders from superior officers and cadets. I certify that, to the best of my knowledge, he/she is physically and mentally fit to take part in vigorous activities, I have disclosed all physical/medical/disability limitations, and he/she is not suffering from any communicable disease. I further agree to be responsible for the value of any uniforms and/or equipment loaned him/her, reasonable wear and tear expected. I understand that such uniforms or equipment shall remain the property of the MCI while on loan, and I agree to return them when my child/ward ceases to serve as a cadet, or at any other time upon request of a MCI officer or other authorized agent. I understand that my personal medical insurance is the primary medical policy in force. I also understand that payment of enrollment fees will be required ANNUALLY and payment of uniform fees may be required upon enrollment. I agree, on my child/ward's behalf, that he/she will be bound by all MCI regulations, policies, and amendments thereto that govern his/her membership and conduct. I acknowledge that failure to abide by cadet standards of conduct in or out of uniform, appearance standards, and/or uniform standards could result in discipline, up to and including disenrollment. I further waive any right to challenge in any way any determination made by MCI regarding my child's/ward's continuance of membership in the MCI should he/she violate said regulations.

8a. Signature of Parent/Legal Guardian	**8b.** Date (DD MMM YY)	**8c.** Signature of Witness (MCI Staff)

9. STANDARD RELEASE

I, being the parent/legal guardian of a member of the MCI, in consideration of his/her acceptance and continuance of membership in the MCI, hereby release from any and all claims, demands, actions, or causes of action due to death, injury or illness the following: (1) the government of the United States of America and all its departments and agencies; (2) any jurisdiction (state, county, city, town, district or other political subdivision) where official MCI activities take place; (3) any organization or association, public or private, that sponsors MCI activities; (4) the Marine Cadets of Iowa; (5) all officers, volunteers, representatives, and agents, acting officially or otherwise of the previously mentioned, jurisdictions, organizations, and associations.

I hereby consent to the examination and treatment of my child/ward by the medical facilities of the Department of Defense (DOD), U.S. Coast Guard (USCG), National Oceanographic and Atmospheric Administration (NOAA), U.S. Public Health Service (USPHS), or civilian physicians/medical facilities to determine physical status for participation in the MCI. I further authorize, as may be required, treatment in said facilities in the event of any illness or accident arising aboard DOD, USCG, or NOAA facilities or vessels, or during other authorized MCI activities. This consent includes any medical, anesthesia, or surgical treatment or hospital services rendered under the general and/or special instructions of the attending physician or other physicians assigned his/her care. This consent does not include major surgery unless, in the medical opinion of two physicians, it is reasonably necessary to save life, or where second opinions are similarly impracticable the concurring opinions of other physicians may be excused.

I also grant permission for my child/ward to be transported as a passenger in military and non-military aircraft, vessels and vehicles.

I consent to my child/ward being videotaped and/or photographed and to permit the reproduction and/or publication of same, or of any other videotapes or photographs by any photographic facility of the Department of Defense/Coast Guard or by the MCI or its divisions, or to their use in connection with educational programs or activities of the said organizations, and I further assign to the said organizations all right, title and interest in the above described videotape recordings or photographs for any further use.

This standard release shall remain in effect for the duration of my child/ward's membership in the MCI. I also give my permission for facsimiles of this release to be made, and when presented by an authorized official of the MCI, DOD, USCG, NOAA shall be considered as valid as the original signed by me.

9a. Cadet Full Name

9b. Parent/Guardian Name (Print or Type)	**9c.** Parent/Guardian Signature	**9d.** Date (DD MMM YY)
9e. Name of Witness (MCI Staff)	**9f.** Signature of Witness (MCI Staff)	**9g.** Date (DD MMM YY)

MARINE CADETS OF IOWA USE ONLY – DO NOT WRITE BELOW THIS LINE

MARINE CADETS OF IOWA (MCI)	CADET **REPORT OF MEDICAL HISTORY**	FOR OFFICIAL USE ONLY

NOTICE

THIS DOCUMENT IS AN AUTHORIZATION, CONSENT AND RELEASE FORM. Upon enrollment, the information requested below is required to provide a medical provider an accurate history of illnesses and injuries that may affect the applicant's ability to perform the rigorous and strenuous physical exercise and exposure to living and working environments that are a part of the MCI training program. Also this information will be provided to a medical provider in case of injury or illness while participating in MCI activities. **If taking medications at time of enrollment, list in Block 8.**

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. You are encouraged to consult your private medical provider regarding past illnesses**. Marine Cadets of Iowa recognizes parent rights and choice. MCI does not require proof of vaccinations or any specific vaccination in order to participate in our program. The liability for choosing to be unvaccinated rests solely with the parent and/or cadet.**

MCI retains the right to deny acceptance for enrollment or training to any cadet if upon review of this form it is determined that the cadet is not physically/medically qualified for participation**. Providing false or misleading information on this form is grounds for termination of membership without a refund of fees.**

1. PERSONAL INFORMATION

1a. Last Name	**1b.** First Name	**1c.** MI

1d. Age	**2e.** Date of Birth (DD MMM YY)	**2f.** Sex (Male or Female) ☐ Male ☐ Female	**2g.** Parent/Guardian Name

1h. Home Address	**1i.** City	**1j.** State	**1k.** Zip Code + 4

1l. Primary Phone	**1o.** Secondary Phone Number

2. MEDICAL PROVIDER/INSURANCE INFORMATION

2a. Medical Insurance Provider Name	**2b.** Medical Insurance Policy Number
2c. Medical Insurance Provider Address	**2d.** Medical Insurance Provider Phone
2e. Medical Provider Name	**2f.** Medical Provider Phone Number

3. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 8: explain treatment to return cadet to medically fit for MCI)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	**YES**	**NO**		**YES**	**NO**
3a. Tuberculosis or live with someone with tuberculosis	☐	☐	**3n.** Head injury or concussion	☐	☐
3b. Chronic or recurrent abdominal or stomach pain	☐	☐	**3o.** Seizures, convulsions, epilepsy, or fits	☐	☐
3c. Asthma or breathing problems related to exercise, pollen, etc.	☐	☐	**3p.** Car, train, sea, and/or air sickness	☐	☐
3d. Been prescribed or use an inhaler	☐	☐	**3q.** A period of unconsciousness	☐	☐
3e. Loss of vision in either eye	☐	☐	**3r.** Heart trouble or murmur	☐	☐
3f. Loss of hearing or wear a hearing aid	☐	☐	**3s.** Received counseling for emotional or behavior disorder	☐	☐
3g. Impaired use of arms, legs, hands, feet	☐	☐	**3t.** Eating disorder (bulimia, anorexia)	☐	☐
3h. Knee problems	☐	☐	**3u.** Sleepwalking	☐	☐
3i. Broken bones(s) (cracked or fractured)	☐	☐	**3v.** Bedwetting	☐	☐
3j. Diabetes	☐	☐	**3w.** Been hospitalized *(if yes, why, when, where)*	☐	☐
3k. Anemia (including sickle cell)	☐	☐	**3x.** Any illness or injury not mentioned above *(if yes, explain)*	☐	☐
3l. Dizziness or fainting spells (including after exercise)	☐	☐	**3y.** Advised to avoid certain physical activities *(if yes, explain)*	☐	☐
3m. Frequent or severe headaches	☐	☐	**This area intentionally left blank.**		

REPORT OF MEDICAL HISTORY

4. ALLERGIES (Mark each item "YES" or "NO". Every item marked yes must be fully explained in Block 8.)

DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	YES	NO		YES	NO
4a. Bee or wasp sting	☐	☐	**4e.** Latex	☐	☐
4b. Hay Fever or seasonal allergies	☐	☐	**4f.** Any drug, e-mycin antibiotic, or sulfa allergies, list in Block 9	☐	☐
4c. Insect bites	☐	☐	**4g.** Other allergies, list in Block 8		
4d. Iodine/seafood	☐	☐	**4h.** Food allergies, list in Block 8		

5. OVER THE COUNTER MEDICATIONS (These medications, or their generic equivalents, may be administered by our staff when requested) ☐ ☐

1.	Allergies:	Benadryl
2.	Colds:	Cough Medicine (Robitussin DM, Dimetapp, etc.), Throat/Cough Drops (Chloraseptic, Halls, etc.), Decongestant (Sudafed, etc.)
3.	Constipation:	Milk of Magnesia, Dulcolax, Ex-Lax, or Glycerin Suppository
4.	Cuts and Scraps:	Bacitracin ointment, Betadine, Neosporin ointment
5.	Diarrhea:	Pepto Bismol, Kaopectate, Imodium AD, etc.
6.	Headache	Tylenol or Ibuprofen (Motrin, Advil, Aleve)
7.	Indigestion:	Calcium Carbonate (Tums, Rolaids, etc.)
8.	Itch/Rash:	Cortisone Cream or Calamine Lotion
9.	Sea/Motion Sickness:	Dramamine, Bonine, etc.
10.	Sprains:	Acetaminophen (Tylenol) or Ibuprofen (Motrin, Advil, Aleve)
11.	Sunburn:	Calamine Lotion, Topical Lidocaine Spray or Aloe Vera Gel
12.	Wounds:	Bacitracin ointments, Betadine, Neosporin Ointment

Other medications not listed above may be administered if so recommended by qualified medical staff.

6. STATEMENT OF UNDERSTANDING AND CONSENT BY INITIALING YOU CERTIFY YOUR UNDERSTANDING & CONSENT TO THE FOLLOWING PARAGRAPHS:	Parent/Guardian Initial Below
6a. I understand that all medications will be 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 over the counter medication.	
6b. I understand and consent that these written instructions may be superseded if, in the opinion of a medical provider, not doing so would place the cadet in a medically compromised condition.	
6c If you do not consent to any or all over-the-counter medications listed above, write "**Do not medicate my child with (a specific or any) over the counter medications**" in Block 7	

7. REMARKS (please include comments as required by Blocks 2, 4, and/or 5. Also provide any other medical history that you or your physician deems important.)

8. 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 Marine Cadets of Iowa, its agents, officials, and training staff members, to dispense medication listed on this Authorization. I "Hold Harmless" the Marine Cadet of Iowa 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 Marine Cadets of Iowa 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.

8a. Parent/Guardian Name (Type or Print)	**8b.** Signature	**8c.** Date (DD MMM YY)

MARINE CADETS OF IOWA (MCI)	CADET APPLICATION **REPORT OF MEDICAL EXAM**	*FOR OFFICIAL USE ONLY*

INSTRUCTIONS

MCI training activities involving strenuous physical exercise and activities such as physical fitness tests and events, confidence courses, rucking (hiking), simulated fighting in an outdoor environment, and martial arts activities, which can often be a hot and humid environment. The medical provider should list any condition(s) that could interfere with full, unrestricted, participation in the MCI. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illnesses, must be listed. A licensed medical provider must complete this examination.

NOTE: In lieu of this form, a "sports" physical from the IAHSAA or IGHSAU may be submitted.

1. PERSONNEL INFORMATION

1a. Last Name	**1b.** First Name	**1c.** MI	**1d MCI** ID Number

REPORT OF MEDICAL EXAM

2. CLINICAL SCREENING (Please check if the patient has any of the following conditions and whether it will affect the ability to participate in strenuous MCI activities.)

Condition(s)	Pre-Existing	NOTES: (Describe every condition in detail. Enter pertinent item number before each comment)
2a. Seizure or convulsion disorder	☐ Yes ☐ No	
2b. Asthma	☐ Yes ☐ No	
2c. Symptomatic/recurring orthopedic injury	☐ Yes ☐ No	
2d. Diabetes, Type I	☐ Yes ☐ No	
2e. Diabetes, Type II	☐ Yes ☐ No	
2f. Hypersensitivity to Food	☐ Yes ☐ No	
2g. Insect bites/stings sensitivity	☐ Yes ☐ No	
2h. Head injuries resulting in residual impairment	☐ Yes ☐ No	
2i. Neurological Impairment	☐ Yes ☐ No	
2j. History of recurring loss of consciousness	☐ Yes ☐ No	
2k. History of debilitating motion sickness	☐ Yes ☐ No	
2l. Sleepwalking	☐ Yes ☐ No	
2m. Bedwetting	☐ Yes ☐ No	

3. MEDICAL PROVIDER ENDORSEMENT (Check all that apply):

I have reviewed the data above, reviewed the patient's medical history form and make the following recommendations for his/her participation in Marine Cadets of Iowa.

3a. ☐ **CLEARED WITHOUT RESTRICTIONS FOR FULL PARTICIPATION**

3b. ☐ Cleared **AFTER** further evaluation or treatment for:

3c. ☐ Cleared for **LIMITED** participation

- ☐ Not cleared for (specify activities):
- ☐ Cleared only for (specify activities):

Reasons:

3d. ☐ **NOT CLEARED FOR PARTICIPATION**

Reasons:

3e. ☐ **OTHER RECOMMENDATIONS**

- ☐ Recommend close monitoring during conditioning because of weight/fitness/other.
- ☐ Recommend restrictions or monitoring of weight loss/gain or fitness concerns.
- ☐ Recommend participation under following condition(s):
- ☐ Other:

4. MEDICAL PROVIDER

4a. Name of Medical Provider (Type or Print) or Medical Provider Stamp	**4b.** Signature (MD, DO, NP, PA)	**4c.** Date (DD MMM YY)

4d. Medical Provider Address	**4e.** City	**4f.** State	**4g.** Zip Code +4	**4h.** Phone

MARINE CADETS OF IOWA (MCI)

CADET APPLICATION
MEDICAL SUPPLEMENTAL

FOR OFFICIAL USE ONLY

NOTICE

This form 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.

MCI retains 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 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

1a. Last Name	**1b.** First Name	**1c.** MI

2. TRAINING INFORMATION

2a. Training Start Date	**2b.** Training End Date	**2c.** Training Location

3. PACKAGING AND LABELING REQUIREMENTS

3a. Prescription Medication
- Must be in the original container from the pharmacy or manufacturer.
- Must have a complete prescription label attached to the container.
- The container will only contain the medication it is labeled for.
- The Cadet must be the person prescribed the medication and his or her name must appear on the prescription label.

3b. Non-Prescription Medication (Over the Counter)
- Must be in the original container from the manufacturer.
- Must have a complete manufacturer's label attached to the container identifying the contents and directions for use.
- The container will only contain the medication it is labeled for.

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

4a. Name of Medication	**4b.** Strength	**4c.** Total Quantity Required	**4d.** Total Quantity Sent

4e. Storage (Use Block 7, if necessary)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:

4f. Frequency and Dosage (check one)
☐ As needed, as labeled ☐ On schedule, as labeled ☐ Other: See Block 4l and/or Block 7

4g. Prescribing Provider Name	**4h.** Prescribing Provider Phone Number	**4i.** Prescribing Provider Phone Number (alternate)

4j. Reason for medication *(Describe in detail if necessary)*

4k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

4l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activities or location.

4m. 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)*

5a. Name of Medication	**5b.** Strength	**5c.** Total Quantity Required	**5d.** Total Quantity Sent

5e. Storage (Use Block 7, if necessary)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:

5f. Frequency and Dosage (check one)
☐ As needed, as labeled ☐ On schedule, as labeled ☐ Other: See Block 5l and/or Block 7

5g. Prescribing Provider Name	**5h.** Prescribing Provider Phone Number	**5i.** Prescribing Provider Phone Number (alternate)

5j. Reason for medication *(Describe in detail if necessary)*

5k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

5l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activates or location.

5m. 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)*

6a. Name of Medication	**6b.** Strength	**6c.** Total Quantity Required	**6d.** Total Quantity Required

6e. Storage (Use Block 7, if necessary)	**6f.** Frequency and Dosage (check one)
☐ Refrigerate ☐ Child-Proof Cap ☐ Other:	☐ As needed, as labeled ☐ On schedule, as labeled ☐ Other: See Block 6l and/or Block 7

6g. Prescribing Provider Name	**6h.** Prescribing Provider Phone Number	**6i.** Prescribing Provider Phone Number (alternate)

6j. Reason for medication *(Describe in detail if necessary)*

6k. Relevant side effects to be observed if any: *(Such as reactions to food, dehydration, sun sensitivity, hives, other medication restrictions, decreased balance/motor skills, hyperactivity, concentration, drowsiness, lethargy, etc.)*

6l. List any other important information about this medication since access to medical information or facilities could be delayed due to training activates or location.

6m. 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)

8. STATEMENT OF UNDERSTANDING AND CONSENT	Parent/Guardian Initial Below
8a. During MCI training evolutions, MCI 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.	
8b. I give consent to the MCI 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 MCI is authorized to obtain medical/prescription information if necessary.	
8c. 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.	
8d. I understand that MCI 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 MCI 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 Marine Cadets of Iowa, its agents, officials, and training staff members, to dispense medication listed on this authorization and I "Hold Harmless" the Marine Cades of Iowa 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 Marine Cadets of Iowa 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.

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

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.

10a. Name of Medical Provider (Type or Print)	**10b.** Signature	**10c.** Date (DD MMM YY)

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.

10d. Name of Commanding Officer (Type or Print)	**10e.** Signature	**10f.** Date (DD MMM YY)

MARINE CADETS OF IOWA (MCI)	CADET APPLICATION **PARENTAL SUPPORT AGREEMENT**	*FOR OFFICIAL USE ONLY*

The adult leadership of Marine Cadets of Iowa is made up entirely of volunteers. Now that your child is joining our program, we ask you to please look over this questionnaire to see if you might be able to help out in some way.

☐ **Yes**, I am willing to help out the unit with the following:

- ☐ Assist with unit recruiting
- ☐ Assist with unit fundraising
- ☐ Assist with unit morale activities (outings, picnics, dances, etc.)
- ☐ Assist with unit administrative functions (copying, typing, etc.)
- ☐ Assist with unit supply (issue uniforms, maintaining inventory)
- ☐ Commit to an annual donation to the unit of $
- ☐ Help with Recruiting or Public Affairs events
- ☐ Organize a car pool from my area for drills and training events

If you can offer assistance with anything else that is not listed above please let us know:

Cadet Name (Last, First, MI Type or Print)

Parent/Guardian Name	Parent/Guardian Name
Relationship to Cadet	Relationship to Cadet
Home Phone	Home Phone
Work Phone	Work Phone
E-Mail Address	E-Mail Address
Times/Days you are available to assist	Times/Days you are available to assist