

CALIFORNIA CADET ACADEMY

APPLICATION

PERSONAL INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ AGE: _____ SEX: _____ DL# _____

CITY/ZIP: _____ ETHNICITY: _____ DOB _____
(Optional)

PHONE NUMBERS: HOME: () _____ CELL PHONE: () _____

WORK: () _____ PAGER: () _____ EMERGENCY: () _____

EMERGENCY INFORMATION: Who do we contact if the parent or guardian cannot be reached and the child must be returned home due to serious illness or injury. This must be an adult to whom the child may be released.

NAME: _____ RELATION TO CHILD: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

DAY PHONE: () _____ EVENING PHONE: () _____

MEDICAL INSURANCE: CARRIER'S NAME & #: _____

MEDI-CAL #: _____

PARENT/GUARDIAN NAME: _____

I hereby give permission to the California Cadet Academy to provide routine health care; to administer medication; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the California Cadet Academy to secure and administer treatment, including hospitalization, for the person named and arrange related transportation for my child.

Parent / Guardian Signature: _____ Date: _____

I authorize the California Cadet Academy to reproduce photographs and video of my child for promotional purposes.

Parent / Guardian Signature: _____ Date: _____