## MEDICAL INFORMATION – TO BE COMPLETED BY ALL APPLICANTS

*This information is For Official Use Only and will not be released to unauthorized persons. Answer all questions as accurately as possible so that the encampment staff are aware of any pre-existing medical problems or conditions and be alert to help you.*

| NAME (Last, First, MI) | CAPID | Date of Birth |
|---|---|---|
| | | |

**Have you ever had an FAA or other flight physical denied, suspended or revoked?** ☐ NO ☐ YES (*Explain in the Remarks section*)

**Do you currently use any medication (Including eye drops/OTC medications)?** ☐ NO ☐ YES (*List ALL medications taken on the reverse*)

**Have you had or been involved in an accident in the past two years?** ☐ NO ☐ YES (*Explain the extent of your injuries in the Remarks section*)

**Have you had or have now any of the following?** (*If you answered 'YES' on any items, please explain why in the Remarks section, including dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with performance during the encampment should also be documented in the Remarks section.*)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ NO | ☐ YES | Frequent or severe headaches | ☐ NO | ☐ YES | Asthma | ☐ NO | ☐ YES | Any drug or narcotic habit |
| ☐ NO | ☐ YES | Dizziness or fainting spells | ☐ NO | ☐ YES | Ear infections | ☐ NO | ☐ YES | Chronic or recurring injuries |
| ☐ NO | ☐ YES | Unconsciousness for any reason | ☐ NO | ☐ YES | Rupture | ☐ NO | ☐ YES | Chronic diseases (like Diabetes or Bronchitis) |
| ☐ NO | ☐ YES | Eye trouble, excluding glasses | ☐ NO | ☐ YES | Positive TB skin test | ☐ NO | ☐ YES | Other illness or accidents |
| ☐ NO | ☐ YES | Hay fever | ☐ NO | ☐ YES | Epilepsy or fits | ☐ NO | ☐ YES | Military rejection or medical discharge |
| ☐ NO | ☐ YES | Sugar or albumin in urine | ☐ NO | ☐ YES | Kidney stones or blood in urine | ☐ NO | ☐ YES | Rejection for life insurance |
| ☐ NO | ☐ YES | Heart trouble | ☐ NO | ☐ YES | Motion sickness | ☐ NO | ☐ YES | Admission to hospital |
| ☐ NO | ☐ YES | High or low blood pressure | ☐ NO | ☐ YES | Nervous trouble of any sort | ☐ NO | ☐ YES | Attempted suicide |
| ☐ NO | ☐ YES | Stomach trouble | ☐ NO | ☐ YES | Any known allergies | ☐ NO | ☐ YES | Medical treatment within the past 5 years other than regular office visits or physicals |

Immunizations

Primary Care Provider (Name, Address and Phone Number of applicant's primary care physician)

## INSURANCE INFORMATION

Name on Policy

☐ Medical Insurance

Company

Policy Number

☐ Liability Insurance

Company

Policy Number

**ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD HERE (Include both Front and Back)**

Remarks (use additional piece of paper if necessary)

## MEDICAL INFORMATION – MEDICATIONS

*List below **EACH** medication that the applicant takes (on any schedule)—**BOTH PRESCRIPTION AS WELL AS OVER-THE-COUNTER MEDICATIONS**. ANY medications not listed below will be confiscated from cadets during Encampment inprocessing. If there are any changes to this information, you may send an updated copy via e-mail to: encampment@wiwg.cap.gov; alternately, contact the encampment staff to notify them of the change and ensure the applicant hand-delivers a new copy of this form to the Encampment staff during inprocessing. By indicating below the medications used by the applicant, you are authorizing the applicant to take those medications on the schedule given.*

*If you need additional space, use the "Remarks" section or list the additional medications on a piece of plain bond paper and include with application.*

| Medication | Dosage | Frequency of Dosage | Reason/Special Instructions |
|---|---|---|---|
| Medication | Dosage | Frequency of Dosage | Reason/Special Instructions |
| Medication | Dosage | Frequency of Dosage | Reason/Special Instructions |
| Medication | Dosage | Frequency of Dosage | Reason/Special Instructions |
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| Medication | Dosage | Frequency of Dosage | Reason/Special Instructions |
| Medication | Dosage | Frequency of Dosage | Reason/Special Instructions |

## PARENT/GUARDIAN (for Cadet Attendees) OR SENIOR ATTENDEE CERTIFICATION

I certify that the information on this ENCF 15B—Medical Information is complete and accurate to the best of my knowledge. And further:

1. I understand that the Encampment medical staff will provide simple first aid care to the attendee, as needed. In the course of this care, I also understand the medical staff may provide common over-the-counter medications (such as aspirin/ibuprofen and Benadryl®, at no cost to the attendee).
[If you do not authorize the medical staff to provide OTC medications, check here ☐.]
2. I understand that, in the case of emergency, the applicant may be transported to a hospital or other urgent care facility that is outside of my insurance carrier's network, that any required prescription refills may occur at an out-of-network pharmacy, and that I will need to contact my insurance carrier to request prior authorization for any services outside of their network. I also understand that the Civil Air Patrol, its Wisconsin Wing and its members will not be financially responsible for any such medical care received or prescriptions filled.

Date _____ Parent/Guardian or Senior Attendee Signature _____