TALLAHASSEE POLICE CADET PROGRAM

MEMBERSHIP REQUIREMENTS

Dear Prospective Member:

The Tallahassee Police Department welcomes your participation in the Cadet Program. The chart below will outline the requirements for your progress as a member. As an active member, you will obtain increased responsibility as you complete each of these stages.

(A) <u>TO BECOME A MEMBER OF THE PROGRAM</u>:

1. You must be 14-21 years of age (if 14 years of age, must be in 9th grade), while continuously enrolled in an approved educational institution;

2. Have never been convicted of felony and no more than one conviction for misdemeanor;

3. Attend three (3) consecutive membership meetings;

4. Complete and turn in the membership information sheet;

5. Complete and turn in participation consent form;

6. Pass a background check;

7. Be approved by the Cadet's Officer Board

7. Pay a $72.00 membership fee.

(B) <u>TO BECOME A UNIFORMED MEMBER OF THE PROGRM</u>:

1. Complete all of the requirements of Section A;

2. Complete a three (3) month probationary period;

3. Attend at least two (2) community service events;

4. Have a working knowledge of the Rules and Regulations Manual;

5. Be approved by the Advisor's Board;

6. Pass the Academy

Revised 08/2021

TALLAHASSEE POLICE CADET
MEMBERSHIP INFORMATION SHEET

PERSONAL DATA

Name_____ DOB_____ Age_____

Current Address_____ Zip_____

Home Telephone #_____ Work Telephone #_____ Cell #_____

Employer_____

Address_____

School Attending_____Grade_____Email_____

PARENTAL DATA

Father's Name_____

Address_____ Home Telephone #_____

Employer_____ Work Telephone #_____

Mother's Name_____

Address_____ Home Telephone #_____

Employer_____ Work Telephone #_____

Any other telephone numbers such as pager or cellular:

Fathers Cell_____ Mothers Cell_____ Other_____

MEDICAL DATA

List any allergies_____

List any medication(s) being used_____

List any medication(s) you are allergic to_____

List any current/past major medical conditions_____

_____

List any condition which might hinder your involvement in strenuous activity_____

_____

Physician's Name_____ Office Telephone #_____

Insurance Company_____ Insurance Number_____

Office Use Only

Dues_____ **BSA Application_____** **Application_____**
TPD Volunteer Application_____ **DAVID_____** **Ntel_____**
NCIC/FCIC_____ **JAC_____** **IIQ/LERMS_____**

PERSONAL INTEREST DATA

How did you become aware of Cadet Program?_____

_____

What are your future goals?_____

_____

What is your interest in Law Enforcement?_____

_____

What are your hobbies and interests?_____

_____

What other civic or school groups are you involved with?_____

_____

What can you offer the Cadet Program?_____

_____

GENERAL INFORMATION

Have you ever been arrested before? List the charges_____

_____

AGREEMENT

As a member of the Tallahassee Police Cadet Program, I agree to abide by all rules and regulations of the Program and the Tallahassee Police Department.

_____

Signature

TALLAHASSEE POLICE DEPARTMENT
CADET PROGRAM

EMERGENCY CONTACT AND CONSENT

Contact Information

NAME_____TELEPHONE_____

ADDRESS_____CITY_____

SCHOOL_____GRADE_____

DATE OF BIRTH_____HEIGHT_____WEIGHT_____

AGE_____HAIR_____EYES_____

PERSONS TO NOTIFY IN CASE OF EMERGENCY:

FATHER_____ADDRESS_____PHONE_____

MOTHER_____ADDRESS_____PHONE_____

ANY OTHER TELEPHONE NUMBERS SUCH AS PAGE OR CELLULAR:

PAGER_____CELLULAR_____OTHER_____

PLACE OF EMPLOYMENT:

FATHER_____PHONE_____

MOTHER_____PHONE_____

TWO OTHERS TO NOTIFY IN CASE OF EMERGENCY:

1. _____PHONE_____

2. _____PHONE_____

CONSENT OF PARENTS (GUARDIANS):

In consideration of the Benefits to be derived, and in view of the fact that the Suwanee River Area Council Boy Scouts of America, is an educational institution, membership in which is voluntary, and having full confidence that every precaution will be taken to ensure the safety and well being of my son/daughter/ward(s) on all activities of Post #916, I hereby agree to his/her participation and waive all claims against the leaders, officers, agents, and representatives of the Boy Scouts of America, Officers, and Advisors of the Tallahassee Police Department, and the City of Tallahassee.

In the event of any medical emergency requiring immediate treatment, I hereby authorize all Post Advisors to give the necessary consent for medical treatment.

DATE_____PARENT OR GUARDIAN_____
Signature

CITY OF TALLAHASSEE POLICE DEPARTMENT

TALLAHASSEE POLICE CADET POST 916

CADET RELEASE OF RESPONSIBILITY

I _____do hereby request permission of the Chief of Police to observe police activities in the company of police officers, in restricted areas, and in other places in the City of Tallahassee when approved by the proper personnel.

This request begins _____and ends upon my termination from the Tallahassee Police Department Cadet program. I am making this request in order to attend and participate in Cadet activities.

Whereas, I fully understand that Law Enforcement and Police activities involve unusual danger to both person and property, and that the Tallahassee Police Department and the City of Tallahassee cannot insure or guarantee my safety as a Cadet, when participating in Cadet activates. I understand that if my request is granted that I assume all risks arising out of the granting of this request.

For and in consideration of the permission and privileges extended to me pursuant to my request to attend and participate in Cadet activities, for myself, my heirs, executors, and personal representatives, I do hereby acknowledge that I am doing so freely and voluntarily, entirely on my own initiative, that I hereby accept all risk and responsibility, and hereby release and discharge the City of Tallahassee, its officers, agents, employees, or other workers or department sponsored programs from any and all liability, claims, and right of action for my death, injury to me or my property, or any other type damage, which may occur in the future arising out of the granting of this request extended to me whether or not they are due to negligence of any officer, agent, employee or other worker of the City of Tallahassee or any program sponsored by the City of Tallahassee or the Tallahassee Police Department.

SPECIFIC DIVISIONS in which the requestor desires to observe activities are:
Special Services Division/ Criminal Investigation Division/ Crime Prevention-Community Affairs/ Patrol Districts A, B, and C.

Date: _____ Signature_____

Date: _____ Signature_____
(Parent/Guardian if a minor)

SWORN TO BEFORE ME ON THIS _____DAYS OF _____20_____.

_____My commission expires_____

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Exploring activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any Exploring volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Exploring activities.

With appreciation of the dangers and risks associated with Exploring programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against Learning for Life, Exploring, the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council, Learning for Life, Exploring, and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Exploring activities, and I hereby release Learning for Life, Exploring, the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/ or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of Learning for Life, Exploring, and the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

NOTE: Due to the nature of programs and activities, Learning for Life, Exploring, the Boy Scouts of America, and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ **None**

_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, **I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met.** The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date:** **Insulin pump: Yes** ☐ **No** ☐
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/ heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma/reactive airway disease	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ Check here if no medications are routinely taken. ☐ If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature — MD/DO, NP, or PA signature (if your state requires signature)

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/mumps/rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		Exemption to immunizations **(form required)**	

Please list any additional information about your medical history:

_____

_____

_____

_____

DO NOT WRITE IN THIS BOX.

Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

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Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in a Learning for Life or Exploring experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin issues	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Learning for Life or Exploring experience. This participant (with noted restrictions):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Has no uncontrolled heart disease, lung disease, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

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