

PERSONAL / MEDICAL / PARENTAL / INFORMATION

List all injuries and serious illnesses you have had in the past *two* years, including dates:

List all surgeries you have had in the past *two* years:

Please list any allergies or allergies to medications that you have:

List the date of your last tetanus shot:

Do you currently have *any* physical or emotional circumstances the academy staff should be aware of?

Are you currently taking any medication? Yes _____ No _____

(List Medication) _____ (How often taken)

FAMILY PHYSICIAN _____
Name Phone #

MEDICAL INSURANCE INFORMATION

Name of Family Medical Insurance: _____

Address City State ZIP

Policy # Subscriber #

(Insurance information must be completed)

Does your Post carry supplemental insurance through WLEEA? Yes _____ No _____

All personal medical insurance will be primary coverage and WLEEA OR BSA coverage will be secondary.)

PARENTAL INFORMATION (if under age 18)

PARENTS OR GUARDIAN: _____
Name Phone #

Address City State Zip

W.L.E.E.A. MEDICAL TREATMENT & RELEASE OF LIABILITY FORM

I, _____ (Parent or Guardian / Self), give my permission to have my dependent/self, (full name) _____ treated at the most available medical facility, in the event said dependent becomes ill or injured. I further understand the WLEEA (Washington Law Enforcement Exploring Advisors) Academy is usually held on a military installation and treatment is often obtained at an off-post facility. I understand I am responsible for the cost of any such treatment. I understand that WLEEA does utilize on-site certified EMT/Paramedic and/or other medically trained personnel to perform first aid and minor injury care, and when necessary emergency medical care. I agree to hold harmless such personnel and their employing agencies and/or WLEEA from any and all liability, action and causes of action, debts, claims, demands of every kind and nature whatsoever, which may arise from the treatment of illness or injury which may occur while at the academy. I authorize the release of medical history / information contained on this application to personnel associated with the treatment or care of above mentioned illness or injury.

I do _____ I do not _____ consent to the use of over the counter medications (advil, cough drops, etc.) being used to treat my dependent / self while at the academy for minor injuries and/or illnesses.

I do _____ I do not _____ wish to be contacted if my dependent is treated for minor injuries / symptoms while at the academy. **(WLEEA will always contact a guardian should a student be treated at a hospital or other emergency medical facility).**

I authorize my dependent / self to participate in the activities of the WLEEA Academy as an Academy student / staff. This authorization acknowledges certain dangers may occur, including, but not limited to, the hazards of strenuous physical exercises, mock scene participation, firearms training, defensive tactics / use of force training and any other duty or circumstances associated with the Washington Law Enforcement Exploring Advisors Academy.

I hereby grant my dependent / self permission to participate in such an Academy, and the activities, events, training and food arrangements of said academy. I do hereby assume all of the above mentioned risks and will hold the Washington Association of Sheriffs and Police Chiefs, WLEEA and their agents, the US Government, Tahoma School District and their agents, Boy Scouts of America, and the agency which sponsors Post # _____ harmless from any and all liability, action and causes of action, debts, claims, demands of every kind and nature whatsoever, which may arise from my participation in or my going to and from any activities arranged for me by the aforementioned parties.

I have adequate insurance coverage through my family to cover my medical needs should I become ill or injured, and understand I must fully bear the cost of such treatment through such coverage.

The terms hereof shall serve as a release and assumption of risks for my heirs, executor and administrators and for all members of my family.

As a legal guardian, or self, I understand the aforementioned and acknowledge so by signing this 3-page form. I swear the information contained on this form, which I have provided, is complete and accurate to the best of my knowledge.

Guardian Signature (If under 18) _____ DATED _____

Advisor Signature _____ DATED _____

Explorer Signature _____ DATED _____