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| **Civil Air Patrol / U.S. Air Force Auxiliary**  **ADULT MEMBER HEALTH FORM**  **(Insurance/Healthcare Provider Information, Emergency Contacts, Voluntary Disclosure** | | | | | |
| **Principal Purpose:** The purpose of this form is to document the potential health conditions, reasonable accommodations, and contact information that may affect the participation in a CAP activity for a CAP member who has reached the age of majority.  **Age of Majority:** The age that the threshold of adulthood as recognized or declared by the state of residence.  **Routine use: Commanders, Activity Directors, and tasked Incident Commanders may require this form to ensure the physical safety of their participants.** This form will be completed the CAP Senior member, retained by the CAP Senior member as part of their property, and temporarily provided to the health services officer, commander, activity director, or tasked incident commander, upon a valid request.  **Disclosure**: Voluntary. However, failure could result in not being able to participate in a CAP activity. | | | | | |
| **Name** *(Last, First, Middle)* | **Grade** | | **CAPID** | | **CAP Unit #** |
|  |  | |  | |  |
| **Mailing Address** *(Number and Street)* | **City** | | | **State** | **Zip Code** |
|  |  | | |  |  |
| *(Area Code)* **Home Phone** | *(Area Code)* **Cell Phone** | | | | |
|  |  | | | | |
| **Primary Insurance Information** *(Please attach copy of insurance cards, front and back)* | | | | | |
| **Healthcare Provider** | | | | | |
| **Name** | | *(Area Code)* **Phone #** | | | |
|  | |  | | | |
| **Email Address** | **City** | | | **State** | **Zip Code** |
|  |  | | |  |  |
| **Emergency Contact** *(to be notified in case of**emergency)* | | | | | |
| **Emergency Contact Name** | | **Relationship to Applicant** | | | |
|  | |  | | | |
| **Mailing Address** *(Number and Street)* | **City** | | | **State** | **Zip Code** |
|  |  | | |  |  |
| *(Area Code)* **Cell/Mobile Phone** | *(Area Code)* **Day Phone** | | | *(Area Code)* **Night Phone** | |
|  | | |  | |
| **Unit Commander Name and Grade** | **Unit Name** | | | | |
|  |  | | | | |
| *(Area Code)* **Unit Commander Day Phone** | *(Area Code)* **Unit Commander Night Phone** | | | | |
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| **Voluntary Medical History Disclosure**  **Note**: The disclosure of your medical history is voluntary but if you were to have an emergency where seconds count, the knowledge of your medical history may provide vital information. | | | | | |
| **Allergies**  I have the following allergies and typical reactions to:   * Over-the-counter medications:       typical reaction includes: * Foods:       typical reaction includes: * Insects:       typical reaction includes: * Environmental allergens:       typical reaction includes: * **I have an epinephrine auto injector (e.g.; Epipen)** * **I have an albuterol inhaler**   **Health Conditions (e.g.; physical, emotional, psychosocial, and/or cognitive) that I have had in the past include:**    **Health Conditions (e.g.; physical, emotional, psychosocial, and/or cognitive) that may become aggravated through participation include:** | | | | | |
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