LOUISIANA ARMY EXPLORERS
APPLICATION AND ENROLLMENT AGREEMENT

☐ CADET ☐ CADRE

AUTHORITY: LAE Regulation 100-2, Enrollment Standards and Procedures.

PRICIPAL PURPOSE: To record enrollment into the Louisiana Army Explorers. This information becomes a part of the Members personnel records which are used to document promotion, reassignment, training, medical support and other personnel management actions. The purpose of soliciting the last (4) of your SSN is for positive identification.

ROUTIE USES: The information contained in this form becomes a part of the Member's record and Field Personnel File. All uses of the form are internal to the Louisiana Army Explorers.

MEMBER IDENTIFICATION DATA

NAME *(Last, First, Middle)*		*SOCIAL SECURITY (last 4 ONLY)* XXX-XX-	
HOME ADDRESS *(Street, City, State, Zip Code)*		*GENDER*	*UNIT OF ASSIGNMENT (Official Use Only)*
HOME PHONE	CELL PHONE	EMAIL ADDRESS	
DATE OF ENROLLMENT (YYYY/MM/DD)	*DATE OF BIRTH (YYYY/MM/DD)*	*ANY PERVIOUS CADETTING EXPERINCE:*	
PLACE OF BIRTH	*CADRE ONLY* PRIOR MILITARY? ☐ ☐ YES or NO BRANCH:_____	If so, you must provide a copy of DD-214. MOS/ JOB:_____ Last Rank:_____	
NAME OF SCHOOL		GRADE	CURRENT GPA
SCHOOL ADDRESS *(Street, City, State, Zip Code)*		PRINCIPAL NAME	OFFICE NUMBER

HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☐ YES ☐ NO
HAVE YOU EVER BEEN SUSPENDED OR EXSPELLED? ☐ YES ☐ NO
If yes to any of these questions, please explain:

HAVE YOU EVER ATTENDED SUMMER SCHOOL? ☐ YES ☐ NO
ARE YOU TAKING PRESCRIBED MEDICATIONS? ☐ YES ☐ NO

CADET'S CUSTODIAL PARENT / GUARDIAN INFORMATION or EMERGENCY CONTACT FOR CADRE

NAME *(Last, First, Middle)*		RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*		EMPOLYER / OCCUPATION	
HOME NUMBER	CELL NUMBER	WORK NUMBER	EMAIL ADDRESS
NAME*(Last, First, Middle)*		RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*		EMPOLYER / OCCUPATION	
HOME NUMBER	CELL NUMBER	WORK NUMBER	EMAIL ADDRESS
NAME *(Last, First, Middle)*		RELATIONSHIP	
HOME ADDRESS *(Street, City, State, Zip Code)*		EMPLOYER / OCCUPATION	
HOME NUMBER	CELL NUMBER	WORK NUMBER	EMAIL ADDRESS

APPLICANT (Cadet and Cadre)AGREEMENT

	Initials
I hereby apply for enrollment in the Louisiana Army Explorers (LAE) of my on free will and desire. If accepted, I agree to abide by the rules and regulations governing the administration and discipline of the L A E .	
I understand uniforms and equipment issued on loan to me remain the sole property of the United States Government or the LAE. I agree to take proper care of the property and upon discharge I will return all issued property within ten days.	
I understand I am accountable to the LAE Code of Conduct and will be held responsible for any actions which bring discredit upon myself, my unit, the LAE, the U .S. Armed Forces.	
I understand the LAE maintains a zero tolerance policy regarding the use or possession of illegal drugs, and alcohol. The use or possession of illegal drugs and alcohol at any time will result in my discharge from LAE.	
I understand I am expected to attend a minimum of 75% of Unit Training Assemblies (UTA), as well as one to two weeks of Annual Training (AT) each summer. Failure to attend UTAs or AT will result in my discharge from LAE.	

SIGNATU RE OF APPLICANT	DATE

CADET'S CUSTODIAL PARENT / GUARDIAN AGREEMENTS

	Initials
I, being the custodial parent, legal guardian or managing conservator of the applicant indicated above, do hereby consent to my child enrolling in the Louisiana Army Explorers. I understand the LAE is not a branch of the military and my child is under no obligation to enlist in the Armed Forces at any time.	
I certify to the best of my knowledge and belief, my child is mentally and physically fit to take part in vigorous activities; is not suffering from any communicable diseases; does not have any pre-existing cardiovascular or orthopedic conditions or complaints; has no allergies or hypersensitivity to medication, insect bites, bee stings or food; history of asthma, diabetes, epilepsy, seizures, convulsions, head injuries requiring hospitalization, periods of loss of consciousness, chronic motion sickness, sleep walking or bed wetting since age eight, and is not currently on any prescription or over the counter medication, including inhalers, except as indicated above and approved by a my Medical Provider and approved by the State Commander that I am applying for by wavier if necessary.	
I agree to be responsible for the value of any uniforms and/or equipment that may be issued on loan to my child, which will remain the sole property of the United States Government or the LAE. I also agree to return issued property immediately should my child cease to serve as a Cadet, or upon the request of an Official of the L A E .	
I fully understand the provisions of the LAE accident insurance plan and acknowledge it does not cover illness unless medically related and incidental to a covered accident resulting from an authorized Annual Training (AT), Unit Training Assembly (UTA), training evolution, community event or recreational activity. I do hereby agree to pay any deductible required by the aforementioned plan. I understand my personal insurance is the primary provider, with LAE coverage as the secondary. In the event I do not have insurance coverage, LAE coverage will become the primary coverage.	
I agree to make payment of the annual registration and insurance fees, and any dues and activity fees. I also understand my child will not be permitted to participate in any activities until said fees are paid.	
I understand attendance at a minimum of 75% of all U TAs or activities is required. Further, I understand that my Child is required to participate in one to two weeks of AT during the summer. If my child misses any three U TAs in a training year or fails to attend AT, he/she may be administratively discharged.	
I consent to the treatment of my child by any available and qualified medical facility of the United States Government, or any civilian physician, physician assistant or nurse practitioner, or civilian medical facility as may be required in the event of illness or injury arising from any authorized activity occurring in a training, recreational or transport status. This consent includes, but is not limited to, any medical, anesthesia or surgical treatment, or hospital services rendered under the general and/or special instructions of the attending physician, physician assistant or nurse practitioner, or other physicians, physician assistants or nurse practitioners assigned to his/her case.	
I hereby grant permission for my child to be transported as a passenger in and by United States Government, corporate, commercial or privately owned and/or operated vehicles, vessels, rail or aircraft. For and in consideration of my child being permitted to travel as a passenger in vehicles, vessels, rail or aircraft operated by, or on behalf of, the United States Government, or the Louisiana Army Explorers, for and on behalf of myself, my personal representatives, heirs and assigns, I hereby release, waive, discharge, acquit and agree to hold harmless, the United States Government, its agents, servants, military personnel and civilian employees, acting in their official capacity or otherwise, and/or the Louisiana Army Explorers, its directors, officers, agents, employees, instructors and volunteers, acting in their official capacity or otherwise, from any and all liabilities, claims, demands, actions or causes of action of every nature and character whatsoever arising out of the death, injury or illness to my child, resulting from or during said travel or continuances thereof or from operations incident thereto.	
I hereby give permission for my child to receive medication while at an authorized AT, UTA, training evolution, community event or recreational activity. I understand the LAE accepts no responsibility for the administration of medication. I hereby release LAE, its agents and employees from any liability that may result from my child taking prescribed and/or over-the-counter medication.	
I hereby release the United States Government, its agents, servants, military personnel and civilian employees, acting in their official capacity or otherwise, and/or the Louisiana Army Explorers, its directors, officers, agents, employees, instructors and volunteers, acting in their official capacity or otherwise and associated personnel acting in their authorized and/or professional capacities for activities related to an authorized AT, UTA, Training Evolution, community event or recreational activity reasonably related and rationally expected of a Cadet. This is intended to include transportation to and from said activities.	

I understand medical care provided at a military medical facility for non-military dependents will normally be rendered on an emergency basis only; if further care is indicated, the patient will be transferred to non-military care as soon as possible. Emergency care provided to Cadets at a military medical facility who are not military dependents may be subject to reimbursement and I may be billed for the care provided.	
I hereby consent to my child's name, likeness, pictures or voice to be used by the LAE or the news media. I am aware that my child may be asked a variety of questions, and the contents of the interview may be published or aired for public view. I understand that my child will be under the supervision of a LAE adult member or agent during interviews and/or photo sessions. I hereby indemnify the LAE respecting any liability for the use of my child's name, likeness, picture and/or voice, and against any claim arising out of my child's acts or statements during an interview, photography session or program.	
I understand, in the event of voluntary or involuntary discharge from LAE, there will be no refund of any annual registration and insurance fees, UTA monthly fees or AT registration fees.	
I agree a photocopy of this agreement shall be as valid as the original.	

REGISTRATION AND INSURANCE FEES

I understand my child's (or as a Cadre Member) enrollment in the LAE is at the discretion of the Unit Commander, based on my child, (or myself as Cadre) motivation to become a Cadet or Cadre, and the level of support provided by their parents (or myself). In consideration of the above, the following Registration and Insurance fees are due upon enrollment, which includes one-year enrollment in LAE, one new or used set of Duty Uniform blouse and trousers; ID Card, nametapes and insignia; patrol cap, LAE shoulder patch, rigger belt, Physical Fitness T-shirt and pair Physical Fitness Shorts. All other items must be purchased separately on my own. Units are authorized to collect additional fees for amounts more than the below initial enrollment fees, which are used for administration; additional uniforms and equipment; an authorized AT, UTA training evolution, community event or recreational activity.
Please indicate your choice of initial payment:

☐ **$250 Registration and Insurance:** Includes the above. Payable upon enrollment.

☐ **$250 Registration and Insurance, Renew**

☐ **$125 Cadre Registration and Insurance**. Includes same as Cadet.

☐ **$25 Cadre Registration and Insurance.** Includes Only ID Card

INSURANCE DATA

DOES APPLICANT HAVE ACCIDENT/ HEALTH/ DENTAL INSURANCE? *(Photocopy required)* ☐ YES ☐ NO	WHICH PARENT/ GUARDIAN HAS PRIMARY HEALTH COVERAGE?
NAME OF INSURANCE COMPANY?	POLICY NUMBER:

CADET'S PATRENTAL OR CADRE CERTIFICATION

-I certify that the information contained herein is accurate and correct.
-As a condition of acceptance; I certify that by initialing above, and signing below, fully understand and agree to the contents of this application.

SIGNATURE OF CADET'S PARENT OR CADRE	DATE

SIGNATURE OF UNIT COMMANDER	DATE

NOTARY STATEMENT

STATE OF_____, COUNTY OF_____,

O n_____, 20_____, before me _____

personally came_____, to me known, and known to me to be the individual(s) described in and who executed the forgoing Parental/Guardian or Cadre Agreement and duly acknowledge to me that (he)(she)(they) executed the same.

SIGNATU RE OF NOTARY PU BLIC

[SEAL]

Commission Expires: _____

LOUISIANA ARMY EXPLORERS
PRESCREEN OF MEDICAL HISTORY REPORT

DATA REQUIRED BY THE PRIVACY ACT OF 1974

The principal purpose and routine use of this information are to obtain medical data for determination of medical fitness prior to enrolling in the Louisiana Army Explorers (LAE) or annual training. This information is for official and medically confidential use only and will not be released to unauthorized persons. Disclosure is voluntary; however, failure by an applicant to provide the information may result in delay or possibly rejection of the individual's application to enter LAE training.

WARNING: The information you have given constitutes an official statement. If you are selected for LAE training based on a false statement, you can meet an administrative board for involuntary discharge from the LAE and dismissal from LAE training while forfeiting training costs.

SECTION I – CADET INFORMATION

1. NAME *(Last, First, Middle)*	2. SSN *(last 4 digits)*	3. SEX ☐ Male ☐ Female

4. DATE OF BIRTH *(YYYYMMDD)*	5. PLACE OF BIRTH *(City, county, state, country)*	6. CURRENT DATE *(YYYYMMDD)*

7. PERMANENT ADDRESS

a. NUMBER AND STREET *(Include apartment no.)*	b. CITY	c. STATE	d. ZIP CODE *(+4)*

8. AFFILIATION	9. UNIT NAME	10. UNIT CITY	11. CADET RANK
☐ Cadet ☐ Cadre			

What Unit of the Louisiana Army Explorers are you applying to, or already belong to?

	First Battalion				Second Battalion			
☐ Headquarters	☐ A co	☐ C co	☐ E co		☐ A co	☐ C co	☐ E co	
☐ HHC	☐ B co	☐ D co	☐ F co		☐ B co	☐ D co	☐ F co	

SECTION II – DRUG AND MEDICAL INFORMATION

12. MEDICATION *(Name as printed on prescription label)*

13. DOSAGE OF MEDICATION *(As indicated on prescription label)*

14. DIAGNOSIS FOR PRESCRIBED MEDICATION *(e.g., seasonal allergies, ADD, etc.)*

15. WARNING ON PRESCRIPTION LABEL *(drowsiness, nausea, etc.)*

16. DRUG ALLERGIES OR OTHER ALLERGIES

17. HISTORY OF FOOD OR ENVIRONMENTAL ALLERGIES THAT RESULTED IN AN ANAPHYLACTIC RESPONSE? ☐ YES ☐ NO

If YES, Cadet must report to training with two (2) EpiPens *(Prescribed in Cadet's name and within 30 days of expiration date)* to be stored in the Medical Department.

SECTION III – AUTHENTICATION

18. PRESCRIBING PHYSICIAN *(Required for Cadet with prescribed medications)*

a. NAME *(Last, First, Middle)*	b. TELEPHONE NUMBER *(xxx-xxx-xxxx)*	c. SIGNATURE

19. PARENT OR LEGAL GUARDIAN

a. NAME *(Last, First, Middle)*	TELEPHONE NUMBER *(xxx-xxx-xxxx)*	SIGNATURE

DO NOT WRITE BELOW THIS LINE – OFFICIAL USE ONLY

20. UNIT S-1

a. NAME *(Last, First, Middle)*	☐ Complete ☐ Deficient	c. SIGNATURE

21. UNIT COMMANDER

a. NAME *(Last, First, Middle)*	☐ Approve ☐ Disapprove	c. SIGNATURE

LOUISIANA ARMY EXPLORERS
REPORT OF MEDICAL HISTORY

☐ CADET or ☐ CADRE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

The primary collection of this information is from individuals seeking to join the Louisiana Army Explorers (LAE). The information collected on this form is used to assist LAE Officials in making determinations as to acceptability of applicants for service and verifies disqualifying medical condition(s) noted on the prescreening form (LAE Form 2). This information is for official and medically confidential use only and will not be released to unauthorized persons. Disclosure is voluntary; however, failure by an applicant to provide the information may result in delay or possibly rejection of the individual's application to enter the LAE. An applicant's SSN is used during the recruitment process to keep all records together.

WARNING: The information you have given constitutes an official statement. If you are selected for training, enrollment, or entrance into a commissioning program based on a false statement, you can meet an administrative board for discharge and could receive an involuntary discharge that may affect your future. Your medical history is required to be on the LAE Form 2-1 "Report of Medical History" and your physical exam is required to be on LAE FORM 2-2 "Report of Medical Examination."

1. APPLICANT'S NAME *(Last, First, Middle)*	2. SSN *(Last four digits)*	3. TODAY'S DATE (*YYYYMMDD*)

4a. HOME ADDRESS *(Street, City, State, Zip+4)*	5. EXAMINING LOCATION AND ADDRESS *(Name, Street, City, State, Zip+4)*
4b. HOME TELEPHONE *(xxx-xxx-xxxx)*	

X ALL APPLICABLE BOXES:

6. PURPOSE OF EXAMINATION

☐ Enrollment ☐ Retention ☐ Appointment
☐ Commission ☐ Training ☐ Annually
☐ Other (*Specify)*:

7a. POSITION (*Title, Rank, Component*)

7b. USUAL OCCUPATION

8. CURRENT MEDICATION (*Prescription and over-the-counter*)

9. ALLERGIES (*Including insect bites/stings, foods, medicine or other substance*)

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10 a. Tuberculosis		
b. Lived with someone who had tuberculosis		
c. Coughed up blood		
d. Asthma or any breathing problems related to exercise, pollens, etc.		
e. Shortness of breath		
f. Bronchitis		
g. Wheezing or problems with wheezing		
h. Been prescribed or used an inhaler		
i. A chronic cough or cough at night		
j. Sinusitis		
k. Hay fever		
l. Chronic or frequent colds		
11 a. Severe tooth or gum trouble		
b. Thyroid trouble or goiter		
c. Eye disorder or trouble		
d. Ear, nose, or throat trouble		
e. Loss of vision in either eye		
f. Worn contact lenses or glasses		
g. A hearing loss or wear a hearing aid		
h. Surgery to correct vision (*RK, PRK, LASIK, etc.*)		
12 a. Painful shoulder, elbow or wrist (*e.g., pain, dislocation, etc.*)		
b. Arthritis, rheumatism, or bursitis		
c. Recurrent back pain or any back problem		
d. Numbness or tingling		
e. Loss of finger or toe		

12. *(Continued)*	YES	NO
f. Foot trouble (*e.g., pain, corns, bunions, etc.*)		
g. Impaired use of arms, legs, hands, or feet		
h. Swollen or painful joint(s)		
i. Knee trouble (*e.g., locking, giving out, pain or ligament injury, etc.*)		
j. Any knee or foot surgery including arthroscopy		
k. Any need to use corrective devices such a prosthetic devices, etc.		
l. Bone, joint, or other deformity		
m. Plate(s), screw(s), rod(s) or pin(s) in any bone		
n. Broken bone(s) (*cracked or fractured*)		
13 a. Frequent indigestion or heartburn		
b. Stomach, liver, intestinal trouble, or ulcer		
c. Gall bladder trouble or gallstones		
d. Jaundice or hepatitis (*liver disease*)		
e. Rupture/hernia		
f. Rectal disease, hemorrhoids or blood from the rectum		
g. Skin diseases (*e.g., acne, eczema, psoriasis, etc.*)		
h. Frequent or painful urination		
i. High or low blood sugar		
j. Kidney stone or blood in urine		
k. Sugar or protein in urine		
l. Sexually transmitted disease (*syphilis, gonorrhea, genital warts, etc.*)		
14 a. Adverse reaction to serum, food, insect stings or medicine		
b. Recent unexplained gain or loss of weight		
c. Currently in good health *(If no, explain in Item 29 on Page 2)*		
d. Tumor, growth, cyst, or cancer		

LAST NAME – FIRST NAME – MIDDLE NAME (SUFFIX)	SSN *(Last four digits)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
5 a. Dizziness or fainting spells		
b. Frequent or severe headache		
c. A head injury, memory loss or amnesia		
d. Paralysis		
e. Seizures, convulsions, epilepsy or fits		
f. Car, train, sea, or air sickness		
g. A period of unconsciousness or concussion		
h. Meningitis, encephalitis, or other neurological problems		
16 a. Rheumatic fever		
b. Prolonged bleeding (*as after an injury or tooth extraction, etc.*)		
c. Pain or pressure in the chest		
d. Palpitation, pounding heart or abnormal heartbeat		
e. Heart trouble or murmur		
f. High or low blood pressure		
17 a. Nervous trouble or any sort (*anxiety or panic attacks*)		
b. Habitual stammering or stuttering		
c. Loss of memory or amnesia, or neurological symptoms		
d. Frequent trouble sleeping		
e. Received counseling of any type		
f. Depression or excessive worry		
g. Been evaluated or treated for a mental condition		
h. Attempted suicide		
i. Used illegal drugs or abused prescription drugs		
18 FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder		
b. A change of menstrual pattern		
c. Any abnormal PAP smears		
d. First day of last menstrual period (*YYYYMMDD*):		
e. Date of last PAP smear (*YYYYMMDD*):		

12. *(Continued)*	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions		
c. Inability to stand, sit, kneel, lie down etc.		
d. Other medical reasons (*If yes, give reasons.*)		
20. Have you ever been treated in an Emergency Room? (*If yes, for what?*)		
21. Have you ever been a patient in any hospital? (*If yes, specify when, where, why, and name of doctor and complete address of hospital*)		
22. Have you ever had, or have been advised to have any operations or surgery? (*If yes, describe and give age at which occurred.*)		
23. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details*)		
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)		
25. Have you ever been rejected for military service for any reason? (*If yes, date and reason for rejection.*)		
26. Have you ever been discharged from military service for any reason? (*If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.*)		
27. a. Chicken pox		
b. Measles		
c. German Measles		
d. Mumps		
e. Mono		
28. Other?		

29. EXPLANATION OF "YES" ANSWERS(S) (*Describe answer(s), give date(s) of problem, name of doctors(s) and/or hospitals(s), treatment given and current medical status.*) (*Use additional pages and attach medical documentation if needed.*)

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME – FIRST NAME – MIDDLE NAME (SUFFIX)	SSN *(Last four digits)*

30. IMMUNIZATION HISTORY *(indicate month/day/year for each entry)*				
a. DTaP, DPT, DT, Td *(circle which)*	1	2	3	4
b. Polio vaccine	1	2	3	4
c. MMR (measles/mumps/rubella)	1	2		
d. Hib (Haemophilus influenza type B)	1	2	3	4
e. Hepatitis B	1	2	3	
f. Varicella	1			
g. Pneumovax vaccine (for post splenectomy)	1			
h. Human Papillomavirus Quadravalent vaccine	1	2	3	
I .Other vaccines *(include name and date)*	1	2	3	4
j. Tuberculosis skin test (Mantoux)	1	Result:	2	Result:

31. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.*)

a. COMMENTS

b. TYPED OF PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

LOUISIANA ARMY EXPLORERS
REPORT OF MEDICAL EXAMINATION

CADET ONLY

DATA REQUIRED BY THE PRIVACY ACT OF 1974

The principal purpose and routine use of this information are to obtain medical data for determination of medical fitness for enrollment, induction, appointment and retention for applicants and members of the Louisiana Army Explorers (LAE). Disclosure is voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the LAE.

TO MEDICAL EXAMINER: Please review this applicant's history and complete the physician's report below. Medical clearance for acceptance into the Louisiana Army Explorers is based solely upon the applicant's ability to participate in strenuous physical activity consistent with military living and working environments, as well as extensive physical exercise similar to what would be experienced during military recruit training. Special attention should be given to cardiovascular and orthopedic conditions. The immunization history should be verified. Conditions that may be considered disqualifying include, but are not limited to, symptomatic or recurrent orthopedic complaints; allergies or hypersensitivity to foods, medications, or insect bites/stings; history of asthma; seizures or convulsions; head injuries requiring hospitalization; loss of consciousness; diabetes requiring dietary restrictions or medication; history of chronic motion sickness, sleep walking or bed wetting since age 9. Laboratory findings and pelvic examination are at the discretion of the Licensed Medical Practitioner. Candidates with defective vision sufficient enough to preclude them from activities requiring removal of glasses (or contacts) shall be reviewed on a case-by-case basis. Medical Practitioners should submit statements for consideration of acceptance when a pre-existing condition exists that, in the opinion of the medical examiner, will not become aggravated from strenuous physical activity nor restrict strenuous physical activity.

SECTION I – FOR APPLICANT

1. DATE OF EXAMINIATION *(YYYYMMDD)*	2. SSN *(Last 4 digits)*	3. NAME *(Last, First, Middle)*

4. PERMANENT ADDRESS		5. HOME TELEPHONE NUMBER *(Include Area Code)*

b. NUMBER AND STREET *(Include apartment no.)*		c. CITY	d. STATE		e. ZIP CODE *(+4)*

6. RANK	7. DATE OF BIRTH *(YYYYMMDD)*	8. AGE		9. SEX		*10.a.* RACIAL CATEGORY *(X one or more)*	b. ETHNIC CATEGORY
				☐ MALE ☐ FEMALE		☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White	☐ Hispanic/Latino ☐ Not Hispanic/Latino

11. TIS	12. AFFILIATION	13.a. ORGANIZATION UNIT	13.b. City and State
	☐ Enrollment ☐ Basic Cadet Training ☐ School/ Training:_____		

14. Blood Type	15. PURPOSE OF EXAMINATION
	☐ Enrollment ☐ Retention ☐ Other (*Specify)*:_____ ☐ Training

16. NAME OF EXAMINING LOCATION, AND ADDRESS

a. NAME	b. ADDRESS	c. STATE		c. ZIP *(+4)*

17. IMMUNIZATION HISTORY *(indicate month/day/year for each entry)*

a. DTaP, DPT, DT, Td *(circle which)*	1	2	3	4	5
b. Polio vaccine	1	2	3	4	
c. MMR (measles/mumps/rubella)	1	2			
d. Hib (Haemophilus influenza type B)	1	2	3	4	
e. Hepatitis B	1	2	3		
f. Varicella	1				
g. Pneumovax vaccine (for post splenectormy)	1				
h. Human Papillomavirus Quadravalent vaccine	1	2	3		
I .Other vaccines *(include name and date)*	1	2	3	4	
j. Tuberculosis skin test (Mantoux)	1	Result:	2	Result:	

AUTHENTICATION STATEMENT: I, the undersigned, certify that the drug, medical, and immunization history are true to the best of my knowledge.

18. APPLICANT *(Parent or legal guardian must authenticate on behalf of minors 18 years-of-age or younger)*

a. NAME *(Last, First, Middle)*	b. TELEPHONE NUMBER *(Include area code)*	c. SIGNATURE

LAST NAME – FIRST NAME – MIDDLE NAME (SUFFIX)	SSN *(Last four digits)*

SECTION II – FOR PHYSICIAN OR MEDICAL PRACTITIONER *(Refer to instructions in back)*

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Nor-mal	Ab-norm	NE
19. Head, face, neck, and scalp			
20. Nose			
21. Sinuses			
22. Mouth and throat			
23. Ears - General (Int. and ext. canals)			
24. Drums (Perforation)			
25. Eyes – General (*Visual acuity under items 61 – 62*)			
26. Ophthalmoscope			
27. Pupils (Equity and reaction)			
28. Ocular motility (Associated parallel movements, nystagmus)			
29. Heart (Thrust, size, rhythm, sounds)			
30. Lungs and chest (*Include breasts*)			
31. Vascular system (Varicosities, etc.)			
32. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)			
33. Abdomen and viscera (Include hernia)			
34. External genitalia (Genitourinary)			
35. Upper extremities			
36. Lower extremities (Except feet)			
37. Feet (See Item 37 Continued)			
38. Spine, other musculoskeletal			
39. Identifying body marks, scars, tattoos			
40. Skin, lymphatics			
41. Neurologic			
42. Psychiatric (*Specify any personality deviations*)			
43. Pelvic (*Females only*)			
44. Endocrine			

45. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 67 and use additional sheets if necessary.*)

37. FEET (*Continued*) (*Circle category*)

☐ Normal Arch ☐ Mild ☐ Asymptomatic

☐Pes Cavus ☐ Moderate ☐ Symptomatic

☐Pes Planus ☐ Severe

SECTION IV – MEASUREMENTS AND OTHER FINDINGS

45. HEIGHT *(*Inches)	46. WEIGHT *(Lbs.)*	47. MIM WGT – MAX WGT MAX BF%	48. TEMPERATURE	49. PULSE *(At rest)*

50. BLOOD PRESSURE *(Seated position)*			51. RED/GREEN	52. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

53. DISTANT VISION		54. NEAR VISION		
Right 20/	Corr. to 20/	Right 20/	Corr. to 20/	by
Left 20/	Corr. to 20/	Left 20/	Corr. to 20/	by

55. COLOR VISION *(Test used and result)*	56. DEPTH PERCEPTION *(Test used and score)* AFVT
PIP /14	Uncorrected Corrected
57. FIELD OF VISION	58. NIGHT VISION *(Test used and score)*

LAST NAME – FIRST NAME – MIDDLE NAME (SUFFIX)	SSN *(Last four digits)*

59. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY (*Use additional sheets if necessary.*)

60 EXAMINEE/APPLICANT (*check one*)	61. I have been advised of my disqualifying condition ☐ N/A	
☐ IS QUALIFIED FOR LAE SERVICE ☐ IS NOT QUALIFIED FOR LAE SERVICE	a. SIGNATURE OF EXAMINEE	b. DATE (*YYYYMMDD*)

62. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*) (*Use additional sheets if necessary*.)

63. RECOMMENDATIONS – FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*) (*Use additional sheets if necessary*.)

64.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
65.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

66. This examination has been administratively reviewed for completeness and accuracy (*Official LAE Use Only)*.

a. SIGNATURE OF THE STATE DEPUTY COMMANDER	b. GRADE	c. DATE (*YYYYMMDD*)

67. WAIVER GRANTED ☐ YES ☐ NO	b. SIGNATURE OF THE STATE COMMANDER	c. DATE (*YYYYMMDD*)