WOODLAND FIRE EXPLORER POST 911
ANNUAL APPLICATION
OVER 18 YEARS OLD APPLICATION

Application Instructions: Please completely fill-out the following form and obtain your parent/guardian's signature before turning in. Make sure your handwriting is legible and neat. This form will need to be filled out annually. Please note that annual membership dues are required to be paid in full in January of each year.

First Name: _____ Last Name: _____

Circle one: Male Female Year: ____ Date of Birth: ____/____/_____ Cell Phone #: (____) _____-_____

Address: _____ Home Phone #: (____) _____-_____

Circle one: 9 10 11 12 C School: _____

Explorer E-mail address: _____

Parent/ Guardian Information:

First Name: _____ Last name: _____

Address: _____ Phone #: (____) ____-_____

Employer: _____ Work Phone #: (____) ____-_____

Work Address: _____

Emergency Contact (if parent is unavailable):

First Name: _____ Last Name: _____

Address: _____ Phone #: (____) ____ - _____

Relation: _____ 2nd Contact #: (____) ____ - _____

Applicant Personal Health History

Please print in ink.

Name: _____

Date of birth: ____/_____/_____

Home Address: _____ City: _____, Ca ZIP: _____

Check all items that apply, past or present, to your health history. Explain any "yes" answers.

Allergies: food, medicines, insects, plants, other: yes no explain: _____

General information:	yes	no		yes	no		yes	no
Asthma	☐	☐	Heart Trouble	☐	☐	Convulsions/seizures	☐	☐
Diabetes	☐	☐	Hemophilia	☐	☐	Cancer/Leukemia	☐	☐
Kidney Disease	☐	☐	High Blood Pressure	☐	☐	Other: **Explain	☐	☐

If yes, explain: _____

List any mediation(s) taken: _____

List any physical or mental limitations: _____

Please turn form over to complete!! >>>

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Immunizations: (*give date of last inoculation or attach shot record*)

Tetanus toxoid: _____ Pertussis: _____ Mumps: _____

Measles: _____ Diphteria: _____ Polio: _____

Rubella: _____ Flu Shot (optional): _____ _____

Name of Personal Physician: _____ Phone #: (____) _____ - _____

Personal health Insurance Carrier: _____ Policy #: _____

Name of Personal Dentist: _____ Phone #: (____) _____ - _____

Applicant Authorization (Mandatory)

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities associated with the Woodland Fire Department Explorer program, except as noted by me in writing. I have received and read the Insurance Waiver- Release of Liability. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgment of medical personnel dictates.

_____ _____ ____/____/20_____

Applicant printed name Applicant Signature Today's Date

** Please complete and turn-in the photo release waiver and insurance waiver along with this application.*

Explorer Post Advisor Use Only:

Date of Application: _____/_____/20____ Renewal Date: _____/_____/20_____

Application complete: Yes No Parent/Guardian Signature: Yes No

Photo Release Waiver Signed/ On File: Yes No

Annual Dues Paid:$. Date Dues Paid: _____/ _____/ 20 _____

Advisor Signature: _____ Date: _____/ _____/ 20_____

FORM 9-2010 (TK)