



WOODLAND FIRE EXPLORER POST 911

ANNUAL APPLICATION

UNDER 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

Identification: To be filled out by parent of guardian about minor. Please print in ink.

Name: _____ Date of birth: ____/____/____

Name of parent/guardian: _____ Phone #: (____) ____ - _____

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	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other: **Explain	<input type="checkbox"/>	<input type="checkbox"/>

If yes, Explain: _____

List any medications 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 #: (____) ____ - ____

Parent 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_____
Parent/guardian printed name Parent/Guardian Signature Today's Date

_____/_____/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____