WCWA CADET CORPS CONSENT TO PARTICIPATE AND MEMBERSHIP APPLICATION

All applicants must be current WCWA Members

Parent/Gardian's Name:_____

Parent/Gardian's Unit:_____ Union Confederate Civilian (circle one)

NAME:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell: _____

Medical History: Please list any medical information/allergies the Commander of WCWA Cadet Corps should be aware of in case of emergency:_____

_____

Person to contact in case of emergency:_____

Phone: _____ Relationship:_____

Current Age: _____ Birth Date:_____ WCWA Membership # _____

For my child, I hereby acknowledge that I am fully aware of the nature and purpose of the activities of the Washington Civil War Association (WCWA) and of WCWA Cadet Corps. I understand that these activities are potentially dangerous, and I voluntarily accept any risks involved. I further consent to this child attending and participating in the activities of the WCWA Cadet Corps. I hereby **indemnify and hold harmless** the WCWA, the WCWA Cadet Corps, its Commander, officers and board members. I understand this is a day activity, and that children are to be picked up at the scheduled time promptly and without delay. I agree to be present on the premises of the WCWA event and not to leave the event grounds while my child is at the WCWA Cadet Corp event. I further agree to be bound by the rules and policies of the WCWA Cadet Corps, and to obey the direction of the Commander of VMI at WCWA Cadet Corps events.

Signature of
Parent/Legal Guardian: Date:

MEDICAL RELEASE AND INFORMATION

We, _____, (Parents) hereby give permission for any and all medical and/or dental attention to be administered to our child _____ in the event of accident, injury, sickness, etc., under the direction of the bearer of this letter, until such time as we may be contacted. We also assume the responsibility for the payment of any such treatment.

PARENTS:_____ PHONE:_____

ADDRESS: _____

ADDITIONAL CONTACTS:_____

CHILD'S NAME_____ DOB:_____

MEDICATIONS:_____

INSURANCE CO:_____ PHONE:_____

BILLING ADDRESS:_____

POLICY HOLDER:_____

ID #:_____ GROUP NUMBER:_____ PLAN CODE:_____

PRESCRIPTION DRUG

CO:_____ PHONE:_____

BILLING ADDRESS:_____

POLICY HOLDER:_____

ID#:_____ GROUP NUMBER:_____ PLAN CODE:_____

DENTIST:_____ PHONE:_____

ADDRESS:_____

SIGNATURE (Parents) _____

SIGNATURE: (Parents) _____