

**SKAMANIA COUNTY SHERIFF'S OFFICE LAW ENFORCEMENT EXPLORER
PROGRAM APPLICATION**

NAME: _____
Last First Middle

ADDRESS: _____
Street Address/P.O. Box #

City State Zip

PHONE: _____
Home Cell phone or Message line

T-shirt Size: Small _____ Medium _____ Large _____ X Large _____ XX Large _____ 3X Large _____

Pant size: Waist _____ Length _____

PERSONAL INFORMATION

Date of Birth ____/____/____ Last school grade completed _____ Sex _____

EMERGENCY NOTIFICATION: _____
Name Phone #

FOR ADVISOR ONLY

Is Explorer currently a member of Learning for Life? Yes _____ No _____

Is payment of \$20.00 sent with this application? Yes _____ No _____

If "NO", please explain why payment was not sent: _____

ADVISORS/PARENTS/EXPLORERS – PLEASE CHECK THE SIGNATURE PAGE
Applications failing to have mandatory signatures/dates may result in delay, or non-acceptance of the applicant into the Explorer Program.

PERSONAL / MEDICAL / PARENTAL / INFORMATION

List all injuries and serious illnesses you have had in the past *two* years, including dates:

List all surgeries you have had in the past *two* years:

Please list any allergies or allergies to medications that you have:

List the date of your last tetanus shot:

Do you currently have **any** physical or emotional circumstances the Sheriff's Office should be aware of?

Are you currently taking any medication? Yes _____ No _____

(List Medication)

(How often taken)

FAMILY PHYSICIAN _____
Name Phone #

MEDICAL INSURANCE INFORMATION

Name of Family Medical Insurance: _____

Address City State ZIP

Policy # Subscriber #
(Insurance information must be completed)

(All personal medical insurance will be primary coverage and Learning for Life (BSA) coverage will be secondary.)

PARENTAL INFORMATION (if under age 18)

PARENTS OR GUARDIAN: _____
Name Phone #

Address City State Zip

SKAMANIA COUNTY EXPLORER PROGRAM MEDICAL TREATMENT & RELEASE OF LIABILITY FORM

I, _____ (Parent or Guardian / Self), give my permission to have my

dependent/self, (full name) _____ treated at the most available medical facility, in the event said dependent becomes ill or injured. I further understand the Skamania County Explorer Program is usually held at the Sheriff's Office and treatment is often obtained at an off-site facility. I understand I am responsible for the cost of any such treatment. I understand that the Skamania County Sheriff's Explorer Program does utilize certified EMT/Paramedic and/or other medically trained personnel to perform first aid and minor injury care, and when necessary emergency medical care. I agree to hold harmless such personnel and their employing agencies and/or Skamania County Sheriff's Office from any and all liability, action and causes of action, debts, claims, demands of every kind and nature whatsoever, which may arise from the treatment of illness or injury, which may occur while in the Explorer Program. I authorize the release of medical history / information contained on this application to personnel associated with the treatment or care of above mentioned illness or injury.

I do _____ I do not _____ consent to the use of over the counter medications (advil, cough drops, etc.) being used to treat my dependent / self while participating in the Explorer Program for minor injuries and/or illnesses.

I do _____ I do not _____ wish to be contacted if my dependent is treated for minor injuries / symptoms while participating in the Explorer Program. **(The Skamania County Sheriff's Office will always contact a guardian should a explorer be treated at a hospital or other emergency medical facility).**

I authorize my dependent / self to participate in the activities of the Skamania County Explorer Program as an Explorer. This authorization acknowledges certain dangers may occur, including, but not limited to, the hazards of strenuous physical exercises, mock scene participation, firearms training, defensive tactics / use of force training and any other duty or circumstances associated with the Skamania County Sheriff's Office Law Enforcement Exploring Program.

I hereby grant my dependent / self-permission to participate in such an activities, events, and training. I do hereby assume all of the above mentioned risks and will hold the Skamania County Sheriff's Office and their agents, the US Government, Boy Scouts of America, and the Skamania County Explorer Post # 0910 harmless from any and all liability, action and causes of action, debts, claims, demands of every kind and nature whatsoever, which may arise from my participation in or my going to and from any activities arranged for me by the aforementioned parties.

I have adequate insurance coverage through my family to cover my medical needs should I become ill or injured, and understand I must fully bear the cost of such treatment through such coverage. Learning For Life (BSA) will provide secondary insurance.

The terms hereof shall serve as a release and assumption of risks for my heirs, executor and administrators and for all members of my family.

As a legal guardian, or self, I understand the aforementioned and acknowledge so by signing this 3-page form. I swear the information contained on this form, which I have provided, is complete and accurate to the best of my knowledge.

Guardian Signature (If under 18) _____ DATED _____

Advisor Signature _____ DATED _____

Explorer Signature _____ DATED _____