NAVAL JUNIOR RESERVE OFFICERS TRAINING CORPS (NJROTC) STANDARD RELEASE FORM

Date: _____

I, _____, being the legal parent/guardian of _____, a member of the Naval Junior Reserve Officers Training Corps, in consideration of the continuance of his/her membership in the Naval Junior Reserve Officers Training Corps and/or his/her acceptance for Naval Junior Reserve Officers Training Corps training, do hereby release from any and all claims, demands, actions, or causes of action, due to death, injury, or illness, the government of the United States and all its officers, representatives, and agents acting officially and also the local, regional, and national Navy Officials of the United States.

I hereby authorize personnel of the Department of Defense, Armed Forces, Public Health Service, or civilian physicians to render such medical and dental care as may be necessary and medically indicated in the case of my son/daughter/ward during his/her period of training, as is deemed necessary by a qualified practitioner.

I understand that care at a military medical facility for non-military dependents will normally be rendered on a temporary (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 who are not military dependents at a military facility may be subjected to reimbursement, and I may be billed for the care provided. For Navy Medical Department facilities, such care is authorized by NAVMEDCOMINST 6320.3B.

My son/daughter/ward has been determined to have the following allergies:
He/she requires medication for the treatment of:

Below are listed other medical conditions which my son/daughter/ward is known to have, which would preclude or limit in any way his/her participation in physical exercise and athletic programs.
His/her physician is:
Name:
Address:
Telephone (include area code):

Initials _____

Medical Insurance Company *
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

Dental Insurance Company*
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

*__This insurance is not required. However, the information provided may be required to obtain non-emergency care.__

PRIVACY ACT NOTIFICATION Under the authority of 5 U.S.C. Sec. 301, the information regarding your child's/ward's health, medical condition and treatment is requested in order to verify any need to administer medication and to enable medical/dental personnel to diagnose and treat any emergency condition which may arise during training. Pursuant to the Privacy Act, 5 U.S.C. Sec. 552, the requested information will not be divulged without your written authorization to anyone other than NJROTC area personnel involved with administration of NJROTC activities and medical/dental personnel requiring the information in order to effectively treat any medical/dental problem which may arise. Disclosure is voluntary: however, failure to provide the requested information will preclude your child's/ward's participation in the training.

Signature of Parent or Guardian:		
Address:		
City:	State:	Zip:
Telephone (include area code):		