

**Wolcott Volunteer Ambulance Explorer  
Post 2166**



**Application**



**PHYSICAL CONDITIONS:**

DO YOU or ARE YOU SUBJECT TO:

ASTHMA:	YES / NO	DIABETES:	YES / NO
HEART PROBLEMS:	YES / NO	FAINING SPELLS:	YES / NO
CONVULSIONS:	YES / NO	BLEEDING DISORDERS:	YES / NO
ALLERGIES:	YES / NO		

Identify Allergies: \_\_\_\_\_

ANY CONDITION REQUIRING SPECIAL CARE: YES / NO

Identify Condition: \_\_\_\_\_

ANY SPECIAL MEDICATION REQUIRED FOR ILLNESS OR ALLERGY: YES / NO

Identify Medication: \_\_\_\_\_

ANY RESTRICTION OF ACTIVITY FOR MEDICAL REASONS: YES / NO

Identify Medical Reason: \_\_\_\_\_

**PARENT / GUARDIAN PLEASE READ:** (please explain this section to your child)

By virtue of your signature below you are stating that the information provided in this application is true, furthermore by your signature below you are also in full agreement with the terms and conditions contained within the "STATEMENT OF POLICY FOR EXPLORER POST #2166", also by your signature you have identified that you will live up to your obligation as a parent / guardian of a WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER. Your child will need to perform the following: provide a recent (within last 6 months) medical physical identifying your child's health, (no photo-copy) this document must be signed by your child's physician, and/or will under-go a physical by the physician for the WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION. (Information is available upon request) A copy of your child's birth certificate must accompany this application. The submission of this application does not necessarily indicate membership in the WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER POST #2166. Your child will be notified by an advisor or a member of explorer membership committee as to the disposition of the application. Your child may be contacted by the explorer membership committee for an interview only after the candidates application is accepted.

PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

APPLICANTS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

Interview date: \_\_\_\_\_ Acceptance date: \_\_\_\_\_ Rejection date: \_\_\_\_\_

Membership committee members present: \_\_\_\_\_

I \_\_\_\_\_ have personally appeared before the membership committee for the WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER POST #2166, and here-by testify that I am fully acquainted with the duties of an active member of the aforementioned ambulance association and here-by accept and will perform them to the best of my abilities.

**WAIVER FOR PARTICIPATION IN  
WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION EXPLORER POST #2166.**

IN CONSIDERATION OF YOU ACCEPTING MY CHILD'S APPLICATION FOR  
MEMBERSHIP AND ENTRY;

I HEREBY FOR MYSELF, MY CHILD, MY HEIRS, EXECUTORS AND  
ADMINISTRATORS, WAIVE AND RELEASE ANY AND ALL RIGHTS AND CLAIMS  
FOR DAMAGES I OR MY CHILD MAY HAVE AGAINST THE TOWN OF WOLCOTT OR  
THE WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION AND ITS  
REPRESENTATIVES, SUCCESSORS AND ASSIGNS, FOR ANY AND ALL INJURIES  
SUFFERED BY MYSELF OR MY CHILD AT ANY ACTIVITY SPONSORED BY THESE  
GROUPS.

NOTE: This waiver must be signed in order for the candidate's application to be accepted by the membership  
committee.

PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

ADVISORS SIGNATURE: \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

CHIEF OF ASSOCIATION: \_\_\_\_\_

DATE: \_\_\_\_\_

**WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION  
EXPLORER POST #2166.**

**EMERGENCY NOTIFICATION AND TREATMENT CONSENT FORM**

*PLEASE PRINT ALL INFORMATION*

DEAR PARENT / GUARDIAN;

IF THERE EVER SHOULD BE A SITUATION WHERE YOUR SON / DAUGHTER SHOULD BECOME ILL OR INJURED WHILE UNDER THE DIRECTION OF THE WOLCOTT VOLUNTEER AMBULANCE ASSOCIATION WE NEED TO HAVE THIS INFORMATION ON FILE. THIS INFORMATION WOULD ALLOW US TO CONTACT YOU DURING AN EMERGENCY. ALSO IF WE WERE UNABLE TO CONTACT YOU, WE WOULD BE ABLE TO CONTACT THE PERSON/S IDENTIFIED ON THIS FORM.

WILL YOU PLEASE FILL OUT THE BLANK FORM BELOW AND RETURN IT AT THE NEXT MEETING.

IF THERE IS A CHANGE IN ANY OF THIS INFORMATION PLEASE NOTIFY US IMMEDIATELY. WE WILL REQUIRE YOU TO PROVIDE UPDATES AS INFORMATION CHANGES OCCUR.

MEMBER'S NAME: \_\_\_\_\_  
First Name Middle Initial Last Name

**PARENTAL / GUARDIAN INFORMATION:**

NAME: \_\_\_\_\_  
First Name Middle Initial Last Name Relationship

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

NAME: \_\_\_\_\_  
First Name Middle Initial Last Name Relationship

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

PHYSICIANS NAME: \_\_\_\_\_

PHYSICIANS PHONE: \_\_\_\_\_

IF WE CAN NOT CONTACT YOU, WHO SHOULD WE CALL ?

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TOWN: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TOWN: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TOWN: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**IMPORTANT!!!!!!!!!!**

IF WE ARE UNABLE TO CONTACT YOU OR ANY OF THE ABOVE INDIVIDUALS AND YOUR CHILD IS SICK OR INJURED, BY VIRTUE OF YOUR SIGNATURE BELOW, YOU AFFORD US **PERMISSION** TO IMMEDIATELY SEEK, THE NECESSARY EMERGENCY MEDICAL ATTENTION FOR YOUR CHILD.

PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_

PARENT / GUARDIAN PRINT: \_\_\_\_\_

ADVISORS SIGNATURE: \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

**WOLCOTT AMBULANCE EXPLORER POST #2166 PHOTO RELEASE**

*For explorers under 18 years of age, complete the form below.*

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_ hereby authorize and consent to the use of his/her visual image by the Wolcott Fire Department for appropriate purposes, including but not limited to: still photography, videotape, electronic and print publications and websites. I give this consent with no claim for payment.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Member Name: \_\_\_\_\_

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone \_\_\_\_\_ (in case we need to contact you).

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*For explorers 18 years of age or older, complete the form below.*

I, \_\_\_\_\_, hereby authorize and consent to the use of my visual image by the Wolcott Fire Department for appropriate purposes, including but not limited to: still photography, videotape, electronic and print publications, and websites. I give this consent with no claim for payment.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Member Name: \_\_\_\_\_

Member Signature: \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ (in case we need to contact you).



## CONSENT FORM

### APPROVAL BY PARENTS OR GUARDIANS

(For youth participants and guests under 21 years of age, participating in a Learning for Life activity.)

First name and middle initial of participant/guest \_\_\_\_\_ Last name \_\_\_\_\_

Address \_\_\_\_\_ Birth Date (month/day/year) \_\_\_\_\_

Additional address (need street address if you have a P.O. box) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Area Code and telephone No. (parent's business) \_\_\_\_\_ Area Code and telephone No. (home) \_\_\_\_\_

### APPROVAL

(If two parents/guardians, both need to sign.)

FOR: \_\_\_\_\_ ON \_\_\_\_\_  
Name of activity. Date(s)

**PARENTS/GUARDIANS.** Please read all of the statements on both pages before giving your approval for participation in the activity listed above. I hereby approve and agree to all of the terms, conditions, and waiver of claims of this CONSENT FORM and certify its correctness. Further, I agree that this participant or guest can meet the health and physical fitness requirements of the trip or activity.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medical Release.** In the event of illness or injury occurring to my son or daughter while involved in this Learning for Life trip or activity, I consent to X-ray examination, anesthesia, and/or medical or surgical diagnostic procedures or treatment considered necessary in the best judgment of the attending physician and performed by or under the supervision of a member of the medical staff of the hospital furnishing medical services.

It is understood that in the event of a serious illness or injury, reasonable efforts to reach me will be attempted.

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Physician \_\_\_\_\_ Telephone No. (\_\_\_\_\_) \_\_\_\_\_