DELAWARE STATE FIRE SCHOOL

2026 JUNIOR FIRE ACADEMY APPLICATION

1461 Chestnut Grove Rd, Dover, DE 19904 302-739-4773

CADET INFORMATION

Camper Name (Last Name, First Name)		Date of Birth		Age
Primary Address		City	State	Zip

Parent or Guardian	Primary Phone	Secondary Phone
Parent or Guardian	Primary Phone	Secondary Phone

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact Name	Relationship
Primary Phone	Secondary Phone

Email Address

Shirt Size

Shorts Size

CADET HEALTH INSURANCE INFORMATION

(In case of illness or injury during the camp requiring a hospital visit)

Policy Holder's Name	Insurance Company Name
Policy Number	Group Number
Insurance Company Address	Insurance Company Phone

Copy of Insurance Card requested but not required with application.

CADET NAME _____

CADET MEDICAL HISTORY

Please complete the following and provide any explanation on medical conditions we should be aware of:

- ☐ Non-Insulin or Insulin Dependent Diabetes
- ☐ Heart Problems/Defects or Hypertension
- ☐ Asthma or Respiratory Problems
- ☐ Musculoskeletal Problems
- ☐ Convulsions/Seizures/Epilepsy
- ☐ Fainting Spells
- ☐ Emotional Problems or Mental/Psychological Disorders
- ☐ Nosebleeds
- ☐ Headaches/Migraines
- ☐ Bleeding Disorders
- ☐ Eating Disorders
- ☐ Significant Surgery or Hospitalization within the past year
- ☐ Recent Communicable Illness (Influenza, Chicken pox, etc.)
- ☐ Any Physical Restrictions
- ☐ Other:

ALLERGIES (Medicinal or environmental)

Allergy	Reaction/ Sensitivity	Treatment	Date of Last Reaction (if any)
1			
2			
3			
4			

Does your child suffer from Anaphylaxis and carry an Emergency Epinephrine Injector?

◯ Yes ◯ No

Does your child suffer from Asthma/COPD and carry an Emergency Rescue Inhaler.

◯ Yes ◯ No

Does your child require regular medication to be taken during the hours of the camp?

◯ Yes ◯ No

If yes, please list below

Medication	Purpose	Dosage Schedule	Instructions	Camper Self Medicates?
1				◯ Yes ◯ No
2				◯ Yes ◯ No
3				◯ Yes ◯ No
4				◯ Yes ◯ No
5				◯ Yes ◯ No
6				◯ Yes ◯ No

I give the Staff of the Delaware State Fire School permission to assist with medication administration if required by my child.

Parent/Guardian Signature: _____ Date: _____

CADET NAME _____

If needed, the Cadet has permission to take the following over-the-counter medications if available:

- ☐ Tylenol Acetaminophen
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/Cough medicine
- ☐ Sudafed/Decongestant
- ☐ Pepto Bismol
- ☐ Tums/Antacid
- ☐ Skin Ointments (in case of rash, etc.)
- ☐ Other:

Does you're Cadet have a Special medical or dietary regiment that is to be followed?

◯ Yes ◯ No

If yes, please explain:

MEDICAL EXAMINATION

This sections is to be completed by a physician after reviewing the camper health history with the parent/ guardian. The Parent Guardian must complete all of the Health History information to the best of their knowledge, before meeting with the licensed professional.

Medical Examination - Must be completed in detail

Height: _____ lbs. Weight: ___ in BP _____ Hearing? Left: S NS NE Right: S NS NE

Vision? S NS NE Vision Correction with Glasses/Contacts? Yes No

Ears, Nose, Throat? S NS NE Abdomen? S NS NE Urinalysis? S NS NE

Extremities? S NS NE

Key: S = Satisfactory NS = Not Satisfactory NE = Not Examined

Immunization History

	Completed	Year		Completed	Year
Hep B	Yes or No	_____	Typhoid	Yes or No	_____
Dtap/Tdap	Yes or No	_____	Paratyphoid	Yes or No	_____
DT/Td	Yes or No	_____	Cholera	Yes or No	_____
Hib	Yes or No	_____	Yellow Fever	Yes or No	_____
IPV/OPV	Yes or No	_____	Typhus	Yes or No	_____
PCV7	Yes or No	_____			

Personal or Religious beliefs dictate against immunizations? Yes No

MEDICAL EXAMINATION (CONTINUED)

CADET NAME _____

PHYSICIAN COMPLETING MEDICAL EXAMINATION

Licensed Physician Name: (Last, First, Middle Initial)	Office Phone Number:		
Office Address:	City:	State:	Zip:

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities, except as noted below.

Signature of Licensed Physician: _____

State License Number: _____ Date: _____

HEALTH INFORMATION PRIVACY STATEMENT

The Health history and medical examination form for minors is for health care concerns at the specified event **only.** All records will be handled by staff/volunteers, whose jobs include processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff in order to provide adequate participant safety and health care. This form will be retained for seven years past the age of maturity of the participant (18 yoa). Access to the information will be limited, but copies may be requested from the event sponsor, by the participant, or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Health History and medical Examination Form for Minors is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me or the examining physician.

Parent/Guardian Signature: _____ Date: _____

MEDIA RELEASE AUTHORIZATION

I hereby grant the The Delaware State Fire School and all the organizations/partnerships associated with this academy permission to record my child/ward's or my (if adult participant) likeness and/or voice for use in television, films, radio or printed media to further the aims of the camp program in related campaigns and magazine articles, booklets, posters and in other ways they may see fit. **I do** ◯ **I do not** ◯

Parent/Guardian Signature: _____ Date: _____

EMERGENCY CLAUSE

In the event I cannot be reached in an emergency, I hereby give my permission to academy staff of The Delaware State Fire School and all the organizations/partnership associated with this academy to secure proper medical care for my child as deemed necessary. This permission extends from minor first aid treatment, transport to a hospital, and any necessary injections, anesthesia, surgery, or other medical procedures deemed necessary.

I do ◯ **I do not** ◯

Parent/Guardian Signature: _____ Date: _____