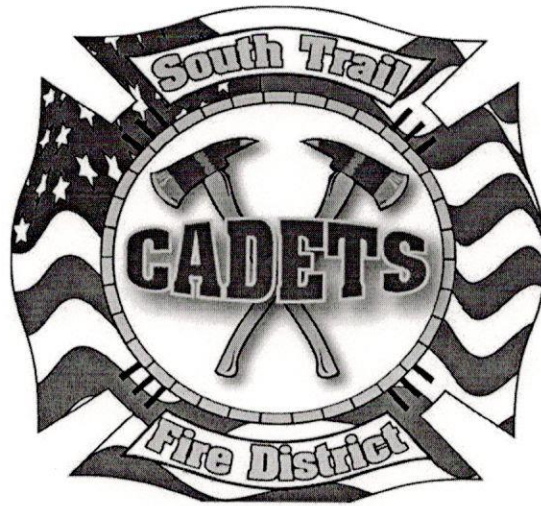


SOUTH TRAIL FIRE & RESCUE CADET POST 5531



APPLICATION PACKET

REVISED 11/2014



SOUTH TRAIL FIRE PROTECTION & RESCUE SERVICE DISTRICT

Business (239) 433-0080
FAX (239) 433-1941
Prevention Division (239) 482-8030
FAX (239) 433-2185

BOARD OF COMMISSIONERS

Richard O. Neville
Chairman

Robert Gaskill
Vice-Chairman

John F. Anderson II
Secretary-Treasurer

Dale Deleacaes
Commissioner

Edwin C. Sokel, Jr.
Commissioner

ADMINISTRATION

William B. Lombardo
Chief

Richard J. Intartaglio
Assistant Chief

September 22, 2010

Dear Explorer or Parent/Legal Guardian of an Explorer:

I first want to thank you for your participation in the South Trail Fire District Explorer program. This program has been very successful and has helped young people from throughout the county to be involved in their community and determine their career choice. In many cases, our Explorers have gone on to successfully complete fire school and some have even began their careers in the fire service. We are very proud of all of the Explorers and hope that you continue with the program.

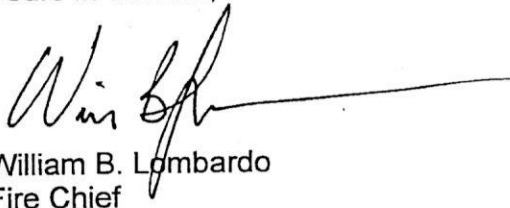
Unfortunately, South Trail Fire District is struggling with a drastically reduced income due to the reduction in property values and the subsequent loss of tax revenue. As a result, we are forced to charge for certain services and programs. The Board of Fire Commissioners unanimously passed South Trail Fire District Resolution #2010-02 at the July 2010 Public Meeting which effectively created a participation fee for our Explorer program effective October 1, 2010.

Under the provisions of the Resolution all existing explorers will be charged an annual fee of \$50 per year (the fee is reduced by 20% for two or more siblings in the program). This fee is due and payable in October of each year. The program is important to the District and we understand that everyone may not be in a financial position to be able to pay the fee; therefore, the Board has made provisions to waive the fee in cases of financial hardship. Please meet with the Lead Explorer Advisor, Matt Brennen if you would like to discuss the financial hardship provision further.

Any new Explorer who enters the program after October 1, 2010 will be charged an initial entry fee of \$100 per person.

A copy of the resolution and schedule of fees is attached for your convenience.

Yours in Service,

A handwritten signature in black ink, appearing to read "W. B. Lombardo", followed by a long horizontal line extending to the right.

William B. Lombardo
Fire Chief

South Trail Fire District

Cadet Post 5531

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Birthdate: _____ Grade: _____ School: _____

Interests: _____

Parent/Guardian Information

Father/Step/Guardian

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Mother/Step/Guardian

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Are there any custody issues that could affect membership of your Cadet? _____

Health/Accident Insurance Co: _____

Please attach a copy of card if applicable.

Any misc. information you feel important to mention so your Cadet has the best experience possible: _____

Parent Authorization for Cadet Participation (if under 18 y/o)

This information is correct so far as I know and the person herein described to me has permission to engage in all activities, except as noted by me in writing to an Advisor of the Post.

In the event that I cannot be reached in case of an emergency, I hereby give permission for proper care to be administered by an Advisor, or to seek and obtain medical treatment, hospitalization, secure proper anesthesia, or to order proper injection for my son or daughter. I also agree to be responsible for medical bills because of said treatments and will indemnify the Fire District and hold the same harmless.

I also give permission for South Trail Fire Department to conduct a background check on my son or daughter. This is done for the protection of all members of the Cadet program; it is also understood that final acceptance into the Cadet Program is pending this background check.

Cadet Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Information about the South Trail Fire Department's Cadet Program for parents and potential explorers:

Annual Cost per Cadet, is \$100 for a new Cadet initial, and \$50 annually thereafter.

Application must be completed in its entirety before Cadet will be allowed to participate.

Upon payment and/or letter of hardship AND membership application, Cadet will be issued:

1x Polo

2x T-Shirts

1 set of bunker gear

1 companion rope

1 SOP Binder

All the above materials are STFD property are valued at \$2,000. Failure to return these items upon leaving the program will result in legal actions to be taken.

The cadet is required to acquire blue BDU style pants, black boots, athletic shoes, and black belt. (Rescue style belt or standard black belt are the only styles accepted.)

All Cadets are expected to be in full uniform by their 4th meeting. Please note "full uniform" includes the Cadet binder and a pen or pencil to write with. If there are any questions, please contact and advisor for further assistance.

Cadet Signature Date

Parent Signature Date

South Trail Fire & Rescue
Cadet Post 5531
Media Talent Release Form

I authorize the broadcast of media (electronic or print) that represents my child. i.e., photos, videos, Facebook, etc.

I DO NOT authorize the broadcast of media (electronic or print) that represents my child. i.e., photos, videos, Facebook, etc.

NOTE: This consent can be revoked by you at any time!

YES NO

Cadet Name: _____ Age: _____

Parent/Guardian Signature: _____

Parent/Guardian Print: _____ Date: _____

FIRE RESCUE CADET MEMBERSHIP APPLICATION

FLORIDA FIRE CHIEFS' ASSOCIATION

880 Airport Road, Suite 110 • Ormond Beach, FL 32174 • 386.676.2744 • 386.676.5490 Fax • info@ffca.org • www.ffca.org

| DEPARTMENT INFORMATION | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------|
| Department: | | SOUTH TRAIL FIRE DISTRICT CADET POST# 5531 | |
| Post Number (if applicable): | 5531 | Post Commander/Dept. Contact: | MATTHEW BRENNAN |
| Address/City/State/Zip: | | 5531 HALIFAX AVENUE, FORT MYERS, FL 33912 | |
| Phone: | 239-433-0080 | Fax: | |
| Email: | mbrennan@southtrailfire.org | Website: | www.southtrailfire.org |
| MEMBERSHIP INFORMATION | | | |
| <input type="checkbox"/> MEMBERSHIP WITH <i>Florida Fire Service</i> (Our monthly magazine) <ul style="list-style-type: none"> <input type="checkbox"/> \$45.00 Per Cadet (July-June of next year) <input type="checkbox"/> \$50.00 Per Cadet (April-June of next year) | | | |
| <input type="checkbox"/> MEMBERSHIP WITHOUT <i>Florida Fire Service</i> <ul style="list-style-type: none"> <input type="checkbox"/> \$15.00 per Cadet (July-June of next year) <input type="checkbox"/> \$20.00 per Cadet (April-June of next year) | | | |
| *NUMBER OF CADETS TO JOIN FFCA: | | | |
| FULL NAME(S) OF CADETS – MEMBERSHIP CARDS AND FLORIDA FIRE RESCUE CADET PATCH(S) WILL BE MAILED TO THE COMMANDER WITH INSTRUCTIONS TO THE CADET ON HOW TO ACTIVATE THEIR WEB BASED SERVICES. <i>(Please add addresses if applying for the membership that receives the Florida Fire Service magazine)</i> | | | |
| CADET NAME: | | CADET NAME: | |
| ADDRESS: | | ADDRESS: | |
| CADET NAME: | | CADET NAME: | |
| ADDRESS: | | ADDRESS: | |
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| ADDRESS: | | ADDRESS: | |
| CADET NAME: | | CADET NAME: | |
| ADDRESS: | | ADDRESS: | |
| DEPARTMENT TYPE | | | |
| <input checked="" type="checkbox"/> Career | <input type="checkbox"/> Combination | <input type="checkbox"/> County | |
| <input type="checkbox"/> City | <input checked="" type="checkbox"/> Special District | <input type="checkbox"/> Volunteer | |
| OPTIONAL – SPONSOR (WHO INTRODUCED YOU TO THE FFCA?) | | | |
| Name: | | Department: | |
| PAYMENT – MAKE PAYABLE TO FLORIDA FIRE CHIEFS' ASSOCIATION | | | |
| <input type="checkbox"/> Check # _____ | <input type="checkbox"/> Visa | <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover <input type="checkbox"/> AMEX |
| Card #: | Expiration Date: ____/____ | Security Code: _____ | |
| Name as it appears on card: | | Bill to of Cardholder: | |
| Membership Year is July 1 – June 30. All memberships are subject to Board of Directors approval. Annual membership dues include \$36 for a one-year subscription to <i>Florida Fire Service</i> . Florida Fire Chiefs' Association is a not-for-profit Corporation – Federal ID# 65-0057476 | | | |



Preparticipation Physical Evaluation (Page 1 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. **This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.**

Part 1. Student Information (to be completed by student or parent)

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
 Personal/Family Physician: _____ City/State: _____ Office Phone: (____) _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

| | Yes | No | | Yes | No |
|-------------------------------------------------------------------------------------------------------------------------------|-----|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | ___ | ___ | 26. Have you ever become ill from exercising in the heat? | ___ | ___ |
| 2. Do you have an ongoing chronic illness? | ___ | ___ | 27. Do you cough, wheeze or have trouble breathing during or after activity? | ___ | ___ |
| 3. Have you ever been hospitalized overnight? | ___ | ___ | 28. Do you have asthma? | ___ | ___ |
| 4. Have you ever had surgery? | ___ | ___ | 29. Do you have seasonal allergies that require medical treatment? | ___ | ___ |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ | 30. Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)? | ___ | ___ |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | ___ | ___ | 31. Have you had any problems with your eyes or vision? | ___ | ___ |
| 7. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? | ___ | ___ | 32. Do you wear glasses, contacts or protective eyewear? | ___ | ___ |
| 8. Have you ever had a rash or hives develop during or after exercise? | ___ | ___ | 33. Have you ever had a sprain, strain or swelling after injury? | ___ | ___ |
| 9. Have you ever passed out during or after exercise? | ___ | ___ | 34. Have you broken or fractured any bones or dislocated any joints? | ___ | ___ |
| 10. Have you ever been dizzy during or after exercise? | ___ | ___ | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? | ___ | ___ |
| 11. Have you ever had chest pain during or after exercise? | ___ | ___ | <i>If yes, check appropriate blank and explain below:</i> | | |
| 12. Do you get tired more quickly than your friends do during exercise? | ___ | ___ | ___ Head | ___ Elbow | ___ Hip |
| 13. Have you ever had racing of your heart or skipped heartbeats? | ___ | ___ | ___ Neck | ___ Forearm | ___ Thigh |
| 14. Have you had high blood pressure or high cholesterol? | ___ | ___ | ___ Back | ___ Wrist | ___ Knee |
| 15. Have you ever been told you have a heart murmur? | ___ | ___ | ___ Chest | ___ Hand | ___ Shin/Calf |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | ___ | ___ | ___ Shoulder | ___ Finger | ___ Ankle |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ___ | ___ | ___ Upper Arm | ___ Foot | |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | ___ | ___ | 36. Do you want to weigh more or less than you do now? | ___ | ___ |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)? | ___ | ___ | 37. Do you lose weight regularly to meet weight requirements for your sport? | ___ | ___ |
| 20. Have you ever had a head injury or concussion? | ___ | ___ | 38. Do you feel stressed out? | ___ | ___ |
| 21. Have you ever been knocked out, become unconscious or lost your memory? | ___ | ___ | 39. Have you ever been diagnosed with sickle cell anemia? | ___ | ___ |
| 22. Have you ever had a seizure? | ___ | ___ | 40. Have you ever been diagnosed with having the sickle cell trait? | ___ | ___ |
| 23. Do you have frequent or severe headaches? | ___ | ___ | 41. Record the dates of your most recent immunizations (shots) for: | | |
| 24. Have you ever had numbness or tingling in your arms, hands, legs or feet? | ___ | ___ | Tetanus: _____ Measles: _____ | | |
| 25. Have you ever had a stinger, burner or pinched nerve? | ___ | ___ | Hepatitis B: _____ Chickenpox: _____ | | |

FEMALES ONLY (optional)

42. When was your first menstrual period? _____
 43. When was your most recent menstrual period? _____
 44. How much time do you usually have from the start of one period to the start of another? _____
 45. How many periods have you had in the last year? _____
 46. What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Student: _____ Date: ____/____/____ Signature of Parent/Guardian: _____ Date: ____/____/____



Preparticipation Physical Evaluation (Page 2 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. **This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.**

Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: ____/____ (____/____, ____/____)

Temperature: _____ Hearing: right: P ____ F ____ left: P ____ F ____

Visual Acuity: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal _____ Unequal _____

| FINDINGS | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|---------------------------|--------|-------------------|-----------|
| MEDICAL | | | |
| 1. Appearance | _____ | _____ | _____ |
| 2. Eyes/Ears/Nose/Throat | _____ | _____ | _____ |
| 3. Lymph Nodes | _____ | _____ | _____ |
| 4. Heart | _____ | _____ | _____ |
| 5. Pulses | _____ | _____ | _____ |
| 6. Lungs | _____ | _____ | _____ |
| 7. Abdomen | _____ | _____ | _____ |
| 8. Genitalia (males only) | _____ | _____ | _____ |
| 9. Skin | _____ | _____ | _____ |
| MUSCULOSKELETAL | | | |
| 10. Neck | _____ | _____ | _____ |
| 11. Back | _____ | _____ | _____ |
| 12. Shoulder/Arm | _____ | _____ | _____ |
| 13. Elbow/Forearm | _____ | _____ | _____ |
| 14. Wrist/Hand | _____ | _____ | _____ |
| 15. Hip/Thigh | _____ | _____ | _____ |
| 16. Knee | _____ | _____ | _____ |
| 17. Leg/Ankle | _____ | _____ | _____ |
| 18. Foot | _____ | _____ | _____ |

* - station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

____ Precautions: _____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

____ Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____



Florida High School Athletic Association

Preparticipation Physical Evaluation (Page 3 of 3)

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written on page 2. **This form is non-transferable; a change of schools during the validity period of this form will require page 1 of this form to be re-submitted.**

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

Cleared without limitation

Disability: _____ Diagnosis: _____

Precautions: _____

Not cleared for: _____ Reason: _____

Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Physician (print): _____ Date: ____ / ____ / ____

Address: _____

Signature of Physician: _____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.

SOUTH TRAIL FIRE DEPARTMENT EXPLORING PROGRAM

POST # _____ MEMBERSHIP APPLICATION

Instructions: All answers are to be typewritten or printed legibly in ink. Each question on this form must be answered, leaving no blanks. If the question does not apply, enter "DNA" in the space provided for the answer. Any false statements made on this application will cause the applicant to not be able to gain membership into the Explorer program.

PERSONAL INFORMATION

| | | | | | |
|-------------------------------------------------|---------------------------------|---------------------------------|-------------------------------------|-------------------------------------|--------------------------------|
| Full Name: | | | | | |
| Alias or Nicknames: | | | | | |
| Residence: | | | Phone Number: | | |
| Number & 4 street | City | State | Zip Code | | |
| Mailing Address: | | | | | |
| Number & Street/PO Box | City | State | Zip Code | | |
| Date of Birth: | | Place of Birth: | | Social Security #: | |
| City | County | State | | | |
| If Naturalized Citizen, List where Naturalized: | | | | | |
| City | County | State | | | |
| Sex: | Age: | Height: | Weight: | Hair: | Eyes: |
| Build: | Light <input type="checkbox"/> | Medium <input type="checkbox"/> | Heavy <input type="checkbox"/> | | |
| I live with: | Father <input type="checkbox"/> | Mother <input type="checkbox"/> | Stepfather <input type="checkbox"/> | Stepmother <input type="checkbox"/> | Other <input type="checkbox"/> |
| Parent/Guardian Names: | | | | | |
| Person to Notify in the Event of an Emergency: | | | | Phone Number: | |

PERSONAL REFERENCE INFORMATION *(List three references other than relatives or past employers)*

| | | |
|-----------|----------|---------------|
| Name: | Address: | Phone Number: |
| Employer: | | Years Known: |
| Name: | Address: | Phone Number: |
| Employer: | | Years Known: |
| Name: | Address: | Phone Number: |
| Employer: | | Years Known: |

SCHOOL INFORMATION

| | | | |
|--------------------------------------------------------------------|----------------------|------------------------------|-----------------------------|
| School Name: | | Counselor's Name: | |
| School Address: | | | |
| Number & 4 street | City | State | |
| Grade Point Average: | Current Grade Level: | Dates of Attendance: | to |
| Have you ever received a referral or detention from school? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "Yes" explain: | | | |
| Have you attended more than one high school in the past two years? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Please attach a copy of your most recent grade report from school | | | |

EMPLOYMENT INFORMATION

| | |
|--------------------------|---------------------------|
| Employer's Name: | Phone Number: |
| Your Job Title: | Number of Hours per Week: |
| Briefly describe duties: | |
| | |
| | |

TRAFFIC INFORMATION

| | | | |
|----------------------------------------------------------------|-------------------|------------------------|-----------------------------|
| Driver License #: | Class of License: | Expiration Date: | |
| <i>List below every driver's license you have been issued:</i> | | | |
| State | Number | Approximate Issue Date | Approximate Expiration Date |
| | | | |
| | | | |

ARREST INFORMATION

| | | | | | |
|-------------------------------------------------------------------------------------------------------------|--------|------------------|---------|------------------------------|-----------------------------|
| Have you ever been detained for investigation, held on suspicion or arrested by any law enforcement agency? | | | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you ever been arrested for any traffic violation? | | | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| <i>If the answer to either of the above is "YES", list the information requested below:</i> | | | | | |
| Date | Charge | Arresting Agency | Penalty | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Remarks: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

By submitting application to the South Trail Fire District Exploring Program, we understand that any appointment tendered will be contingent upon the results of a thorough character investigation conducted by the South Trail Fire District. This investigation may include, but is not limited to, criminal record checks by computer, contacts with law enforcement agencies, personal references, employers (past and present), and officials of schools of attendance.

We are aware any false statements made on this application will cause the applicant to be removed from further consideration for membership.

We hereby waive any claim against the South Trail Fire District, its officers and employees, the Fire Chief, and all members of the Fire Department for pursuing an aggressive and detailed background investigation into the applicant for Fire Explorer. We understand that such investigation shall remain confidential whether or not the applicant is allowed membership as a South Trail Fire District Explorer.

Date: _____ Exploring Applicant's Signature: _____

Date: _____ Parent/Legal Guardian Signature: _____