



WELCOME – OVERVIEW OF SEA CADET TRAININGS 2020

TSR – NAVY LEAGUE ORIENTATION

WINTER TRAININGS

Schedule

Website – www.nefltrainingcommand.org

-ELIGIBILITY

PRT

Coursework

-REGISTRATION REQUIREMENTS

Training Documents

Fees

TIMELINE

ABOUT RECRUIT TRAINING

SEABAG LIST



MAGELLAN

UNITED STATES NAVAL SEA CADET CORPS

MAIN MENU

Level: Unit
Home
Unit Mgmt
Library
Reports
Training Sign-up
Uniform Ordering
My Profile



Cart | Open Invoices | Reminders | Alerts | Inbound Requests | Outbound Requests | Search | FAQ | LOGOUT

FRANKLIN D ROOSEVELT SQUADRON

Navy Shore, NSCC Recruit Training (RT-FL-2011)

12/26/2020 - 1/3/2021

COTC/POC: Donte Mackey | (803) 476-2348 | admin.nesi@seacadets.org

Mailing Address: 56 Royalgate Dr. Columbia, SC 29223 USA

[View Training Details](#)

	Male									Female								
	Event Slots	Submitted Requests ?	Confirmed (Pending Payment) ?	Approved Orders (Payment Rcvd) ?	Avail Slots	SC Needed	SC Filled	EO Needed	EO Filled	Event Slots	Submitted Requests ?	Confirmed (Pending Payment) ?	Approved Orders (Payment Rcvd) ?	Avail Slots	SC Needed	SC Filled	EO Needed	EO Filled
CADETS	80	0	45	2	35	14	14	8	7	20	0	19	0	1				
ADULTS	0	0	8	8	0					0	0	8	8	0	5	5	8	8

Open Registration Period: 6/25/2020 9:00:00 AM - 12/15/2020

COTC's identify requirements for each training ie: age, rank, PRT, etc.
Magellan will reflect any requirements that have not been met according to the database when attempting to register for a training.
Effective 1 April 2015 Magellan will begin enforcing training registration requirements.

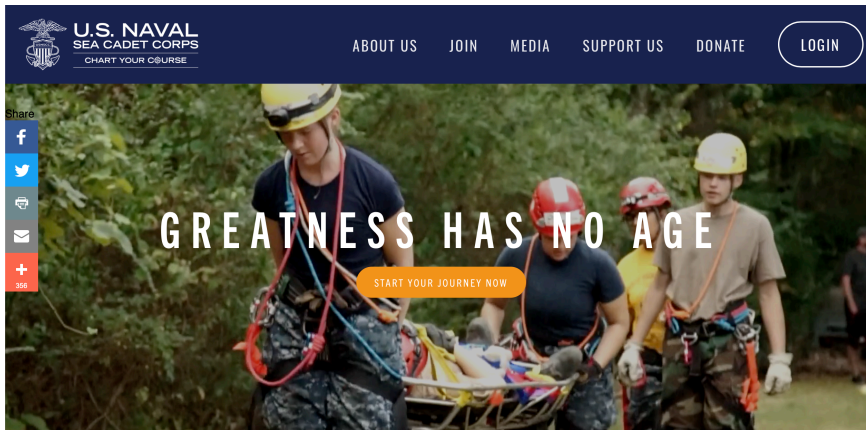
Adults

Adult	Gender	Event Status	Registration Status	Registration Actions	Forms
Brown, Rylee	F	FULL	Not Registered	Add To Waiting List as EO	
Bunner, Karen	F	FULL	Not Registered	Add To Waiting List as EO	
Dees, Margaret	F	FULL	Not Registered	Add To Waiting List as EO	
Dees, Vivian	F	FULL	Not Registered	Add To Waiting List as EO	
Diaz, Oscar Escort Officer	M	FULL	Approved 10/18/2020 6:54:49 PM	Cancel	Print Orders NSCTNG 002 Upload Documents to COTC
Diaz, Rebecca	F	FULL	Not Registered	Add To Waiting List as EO	
Gallo, Colin	M	FULL	Not Registered	Add To Waiting List as EO	

Gender	Event Status	Registration Status	Registration Actions	Forms
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
M	CLOSED Renew Registration	Not Registered		
M	CLOSED Renew Registration	Not Registered		
F	OPEN	Not Registered	Register Register as SC	
F	OPEN	Not Registered	Register Register as SC	
AR	F	OPEN	Does Not Meet Requirements Register as SC	
F	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
M	OPEN	Confirmed - Pending Payment 10/18/2020 6:54:32 PM	Cancel	NSCTNG 001 Upload Documents to COTC
F	OPEN	Not Registered	Register Register as SC	
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
M	CLOSED Renew Registration	Not Registered	Does not meet requirement: E-1 or BMR required to register for RT. Does not meet PRT requirement of 1 passing PRT in past 6 Months.	
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
F	OPEN	Confirmed - Pending Payment 10/18/2020 12:58:32 PM	Cancel	NSCTNG 001 Upload Documents to COTC
M	OPEN	Confirmed - Pending Payment 10/18/2020 6:54:02 PM	Cancel	NSCTNG 001 Upload Documents to COTC
M	OPEN	Confirmed - Pending Payment 10/18/2020 12:58:23 PM	Cancel	NSCTNG 001 Upload Documents to COTC
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
F	OPEN	Confirmed - Pending Payment 10/18/2020 12:58:52 PM	Cancel	NSCTNG 001 Upload Documents to COTC
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
M	OPEN	Confirmed - Pending Payment 10/19/2020 6:43:42 PM	Cancel	NSCTNG 001 Upload Documents to COTC
F	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
M	OPEN	Not Registered	Does Not Meet Requirements Register as SC	
F	OPEN	Not Registered	Does Not Meet Requirements Register as SC	

Landing Page - Cadets

1. Navigate to www.seacadets.org and click the LOGIN button at the top right.

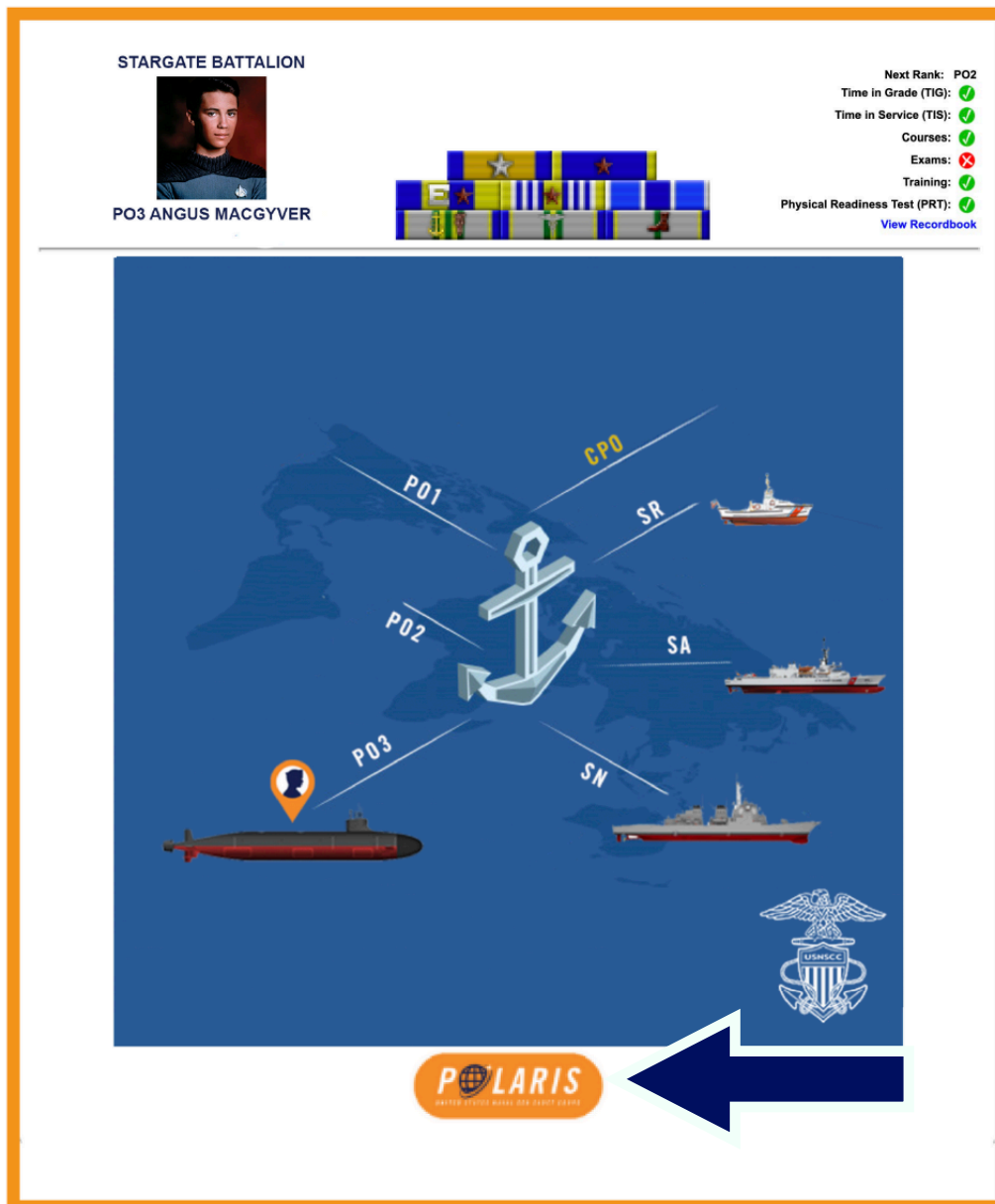


2. Login to the Quarterdeck. First time users must select the **First Time User?** [Click here to Register](#) button.



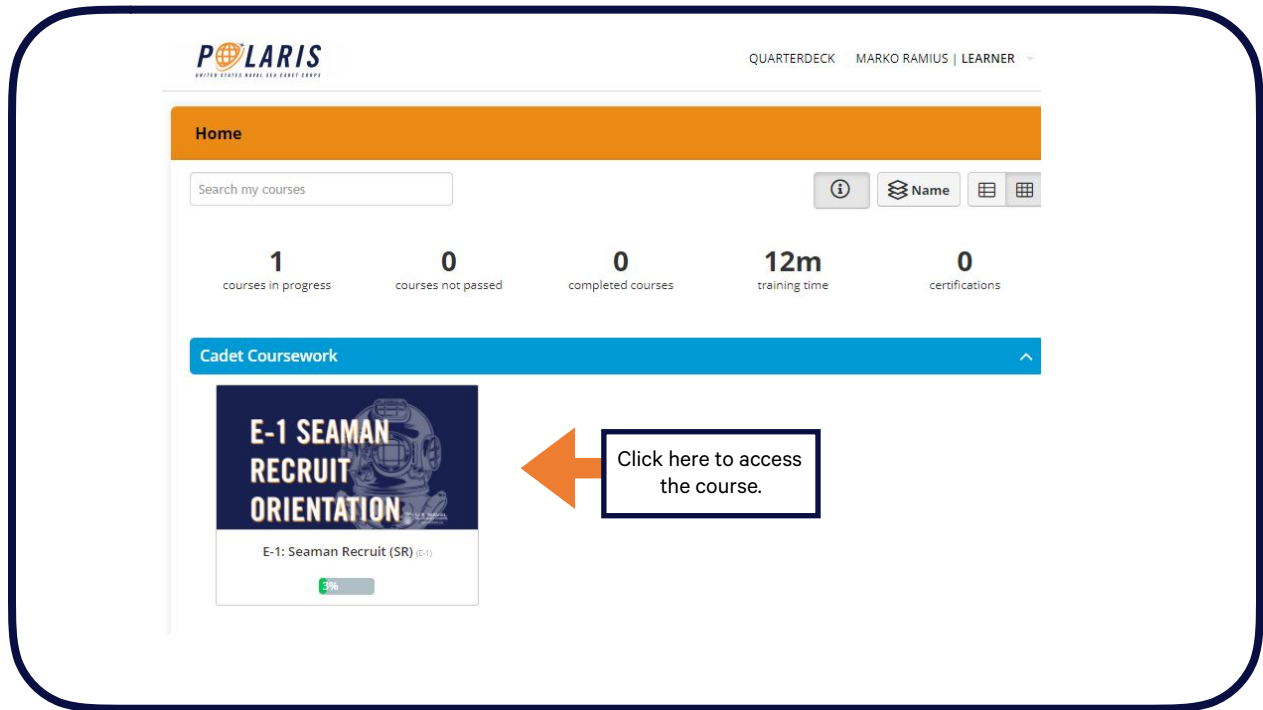
3. This is a cadet's Quarterdeck landing page. Here, they can view their service record and ribbon rack.

Cadets will click the orange *POLARIS* button to access all of their advancement exams and courses.



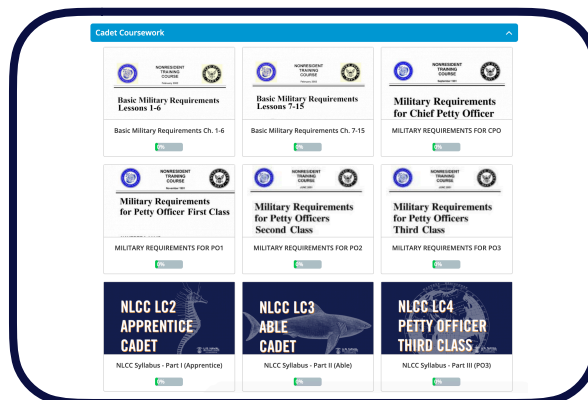
Polaris Dashboard

1. After you select Polaris on the Quarterdeck Landing Page, you will be directed to the Polaris Dashboard.



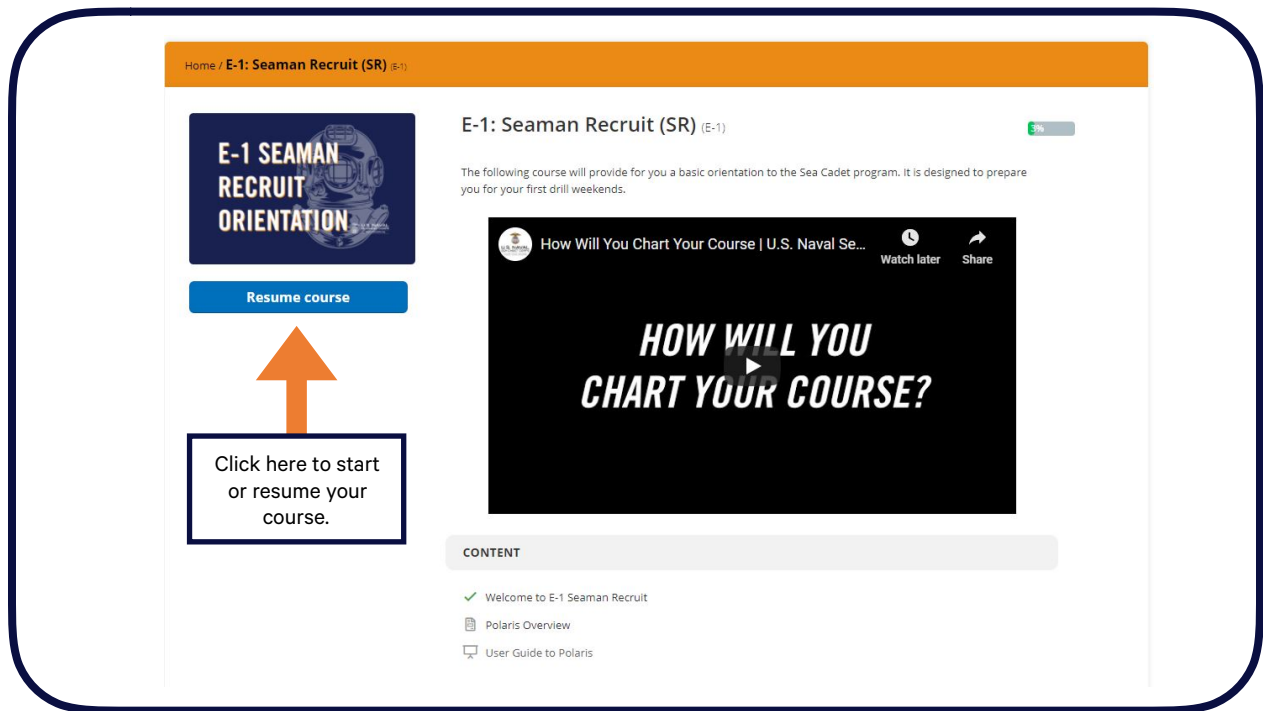
2. The **Cadet Coursework** section shows you what courses you have available or those in which you are enrolled. You will be automatically assigned the courses to which you are eligible based on your current rate.

Above the blue **Cadet Coursework** bar, you can view information on your course progress.

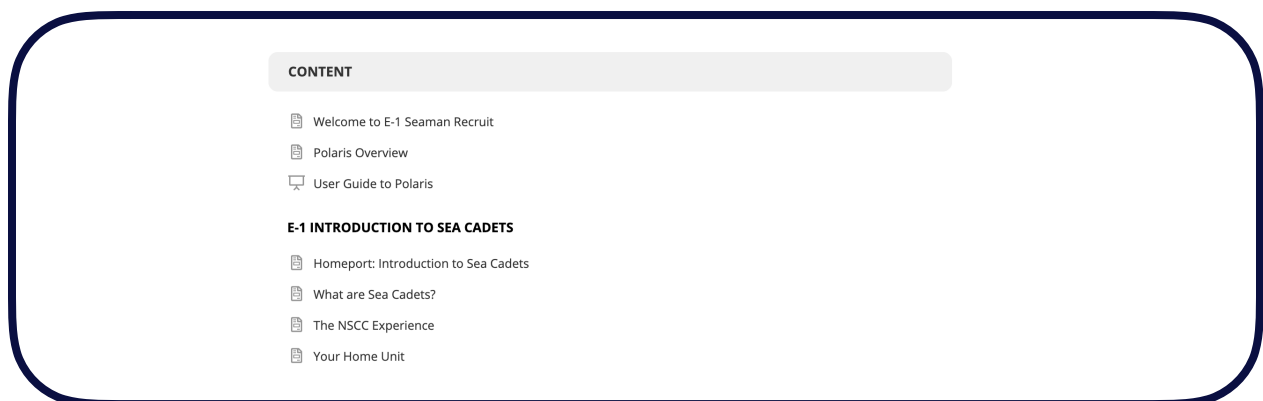


COURSE (PAC) Information

1. Click the blue **Resume course** or **Start course** button to continue with your course.

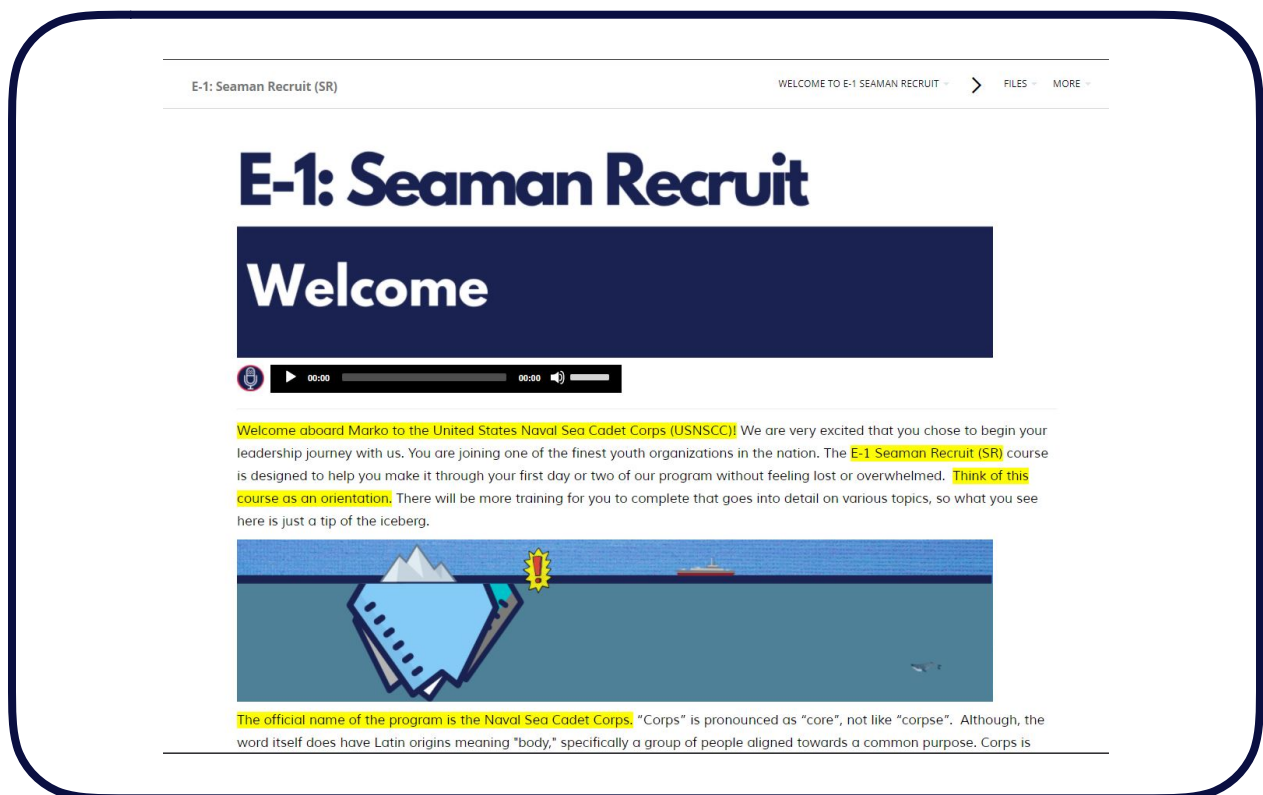


2. The grey **CONTENT** section contains all of the required content that is part of the course. When a lesson is completed, you will see a green check mark. ✓



COURSE Lesson Page

1. The top of the page features a basic navigation bar that allows you to scroll back and forth between lessons and access other resources.
2. Below, you will see a **Lesson Heading**, which will tell you which course and eventually which section and lesson you are currently completing.
3. Below the **Lesson Heading** you can begin reviewing the content of each lesson. This includes additional reading, resources, and other media. Scroll down to continue reading the course material.



...For the rest of this instruction manual go to www.fdrseacadets.org/coursework

Sample Request for Training Authority

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS		REQUEST FOR TRAINING AUTHORITY (CADET)			
INSTRUCTIONS: 1. PREPARE THIS FORM IN DUPLICATE 2. FORWARD ORIGINAL PER TRAINING SCHEDULE 3. FILE A COPY TO SERVICE RECORD					
1a. Date (DD MMM YY) 11/19/2020		1b. Unit Name FRANKLIN D ROOSEVELT SQUADRON			1c. Unit Code 062FDR
2a. Last Name Doe		2b. First Name Jane		2c. MI A	2d. Rate A/R
2e. USNSCC ID 5555XYZ					
2f. Exp. Date 01/30/2021	2g. Date of Birth 01/01/2005	2h. Sex Female	2i. Cadet E-Mail Address janeadoe@gmail.com		
2j. Parent/Guardian Name Gilbert Doe		2j. Parent/Guardian Phone (904) 555-5555		2l. E-Mail Address (if different than above) gilbertdoe@gmail.com	
2m. Home Address 111 Main Street			2n. City Jacksonville		2o. State FL
			2p. Zip Code +4 32222		
3a. Emergency Contact Name (other than Parent/Guardian) Mary Doe			3b. Emergency Contact Primary Phone (904) 444-4444		3c. Emergency Contact Alternate Phone (904) 333-3333
4a. Training Name/Description Navy Shore, NSCC Recruit		4b. Training Location Camp Blanding		4c. Training Code RT-FL-2011	4d. Staff Cadet? No
		4e. Training Start Date 12/26/2020		4f. No. Days 9	
5a. Recruit Training/Orientation complete? Year Completed		5b. Physical Fitness Test passed? Yes		Date Passed 10/01/2020	
The NSCC Physical Readiness Manual outlines minimum fitness standards for Recruit Training. Consult Training Schedule for training evolutions that have specific physical fitness requirements. Cadets who do not meet these minimums will be returned home at their expense.					
6. STATEMENT OF UNDERSTANDING (MEDICAL & STANDARDS OF CONDUCT) BY INITIALING YOU CERTIFY YOUR UNDERSTANDING & CONSENT TO THE FOLLOWING PARAGRAPHS:					Parent/Guardian Initial Below
6a. I have been advised and understand that the training requested by my son/daughter/ward is strenuous and both physically and mentally demanding. I certify that, to the best of my knowledge, my son/daughter/ward has no medical conditions or physical disabilities that would preclude him/her from participating in such training. I understand that should a disqualifying medical or physical condition arise prior to his/her departure for training, that the unit commanding officer will be notified immediately. Further, I understand authority for my son/daughter/ward to participate in the training requested will be cancelled.					
6b. I have been advised and understand that should my son/daughter/ward report for training with a pre-existing medical/physical condition that makes it impossible for him/her to participate in scheduled training activities, or should become either physically or medically disqualified during such training, he/she will be returned home at my expense. Further, I certify that my son/daughter/ward is not under a physician's care and I further understand that he/she may not be eligible to report for training if taking prescription drugs or medication.					
6c. I authorize any Health Care Provider, Insurance Company, Employer, Person, or Organization to release any information regarding medical, dental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient to the Naval Sea Cadet Corps' Accident Insurance Provider, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for audit purposes or for statistical analysis. I understand that I or my authorized representative will receive a copy of this authorization upon request.					
6d. Cadets are responsible for maintaining the highest standards of conduct. Most service component berthing is two to a room and approaches Hotel/Motel standards. I have explained to my child that they are responsible for following ALL COTC instructions, and that improper conduct resulting from violation of instructions (i.e. sneaking out of rooms after-hours, lack of motivation, cheating, disobeying orders, etc.) will be cause for immediate dismissal from the training and they will be returned home at my expense.					
7a. Medical Insurance Provider Name 			7b. Medical Insurance Policy Number 		
7c. Medical Insurance Provider Address 				7d. Medical Insurance Provider Phone 	
8. TRANSPORTATION NOTICE The Department of the Navy no longer has the scheduling authority to support the Naval Sea Cadet Corps for air transportation needs. The NSCC Unit, Unit Sponsor, Council, or individual cadet family MUST provide for transportation to and from the training site. Transportation of NSCC personnel returned home for disciplinary reasons, illness, or at own request, will be at their <u>OWN EXPENSE</u> or at the expense of their <u>PARENT/GUARDIAN, NSCC UNIT, OR UNIT SPONSOR</u> .					
9. ENDORSEMENTS <div style="text-align: center;">THIS FORM WILL NOT BE PROCESSED WITHOUT REQUIRED ENDORSEMENTS</div> <p>By endorsing this form you affirm that the cadet has received a Medical Screening (NSCADM020) and as a result is physically and medically qualified to attend the requested training and that all information provided, to the best of your knowledge, is truthful and accurate; and you consent to the above listed NSCC/NLCC training and all terms and conditions of the preceding paragraphs. NOTE: DEPOSITS ARE NON-REFUNDABLE.</p>					
Parent/Guardian (Print or Type) Gilbert Doe		Signature 		Date (DD MMM YY) 	
Commanding Officer (Print or Type) James Jennings, LT		Signature 		Date (DD MMM YY) 	
Commanding Officer's Primary Phone Number (386) 466-8266		Commanding Officer's Alternate Phone Number ()		Commanding Officer E-Mail Address co.062fdr@seacadets.org	
10. COTC ENDORSEMENT/SIGNATURE					Date (DD MMM YY)

Sample Medical Exam - If you take OTC or prescription Medications - you must also do the Medical Supplemental

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION REPORT OF MEDICAL EXAM	<i>FOR OFFICIAL USE ONLY</i>
INSTRUCTIONS		
Acceptance criteria for the Naval Sea Cadet Corps/Navy League Cadet Corps (NSCC/NLCC) are listed on the reverse side. No one will be denied admission to the program due to a medical disability, however participation may be limited if the cadet is not able to meet the medical standards necessary to FULLY participate in training activities involving strenuous physical exercise and activities such as orientation in fighting shipboard fires in often hot and humid environments. The medical provider should list any condition(s) that could interfere with full, unrestricted, participation in the NSCC/NLCC. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illnesses, must be listed. The history of immunization should be verified to the satisfaction of the medical provider. <u>A licensed medical provider must complete this examination.</u>		
1. UNIT INFORMATION		
1a. Unit Name		1b. Region
2. PERSONNEL INFORMATION		
2a. Last Name	2b. First Name	2c. MI
2d. USNSCC ID Number		
2e. Age	2f. Date of Birth (DD MMM YY)	2g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
2h. Parent/Guardian Name		
2i. Home Address	2j. City	2k. State
2l. Zip Code + 4		
2m. Primary Phone	2n. Alternate Phone	2o. Date of Physical Examination (DD MMM YY)
3. CLINICAL EVALUATION		
Anatomy	Normal	Abnormal
NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment)		
3a. Head, Face, Neck, and Scalp	<input type="checkbox"/>	<input type="checkbox"/>
3b. Nose	<input type="checkbox"/>	<input type="checkbox"/>
3c. Sinuses	<input type="checkbox"/>	<input type="checkbox"/>
3d. Ears – General (Internal and External Canals)	<input type="checkbox"/>	<input type="checkbox"/>
3e. Drum (Perforation)	<input type="checkbox"/>	<input type="checkbox"/>
3f. Eyes- General	<input type="checkbox"/>	<input type="checkbox"/>
3g. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>
3h. Pupils (Equality and Reaction)	<input type="checkbox"/>	<input type="checkbox"/>
3i. Heart (Thrust, Size, Rhythm, and Sounds)	<input type="checkbox"/>	<input type="checkbox"/>
3j. Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>
3k. Abdomen and Viscera (Include Hernia)	<input type="checkbox"/>	<input type="checkbox"/>
3l. External Genitalia (Genitourinary)	<input type="checkbox"/>	<input type="checkbox"/>
3m. Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>
3n. Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>
3o. Feet	<input type="checkbox"/>	<input type="checkbox"/>
3p. Spine and other Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
4. LABORATORY FINDINGS (only required for those with a history of urinary tract infections or anemia, enter N/A if tests were not administered)		
4a. Urinalysis	4b. Blood	
(1) Albumin:	(2) Sugar:	(1) Hemoglobin:
(2) Hematocrit:		
5. MEASUREMENTS AND OTHER FINDINGS		
5a. Height inches	5b. Weight lbs.	5c. Obese <input type="checkbox"/> Yes <input type="checkbox"/> No
5d. Pulse		5e. Blood Pressure (1) Systolic:
(2) Diastolic:		5f. Audiogram (if available)
HZ	500	1000
2000	3000	4000
6000	5g. Wears Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No	
5h. Wears Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No		5i. Uncorrected Vision (1) Left: 20/
5j. Color Vision		(2) Right: 20/
Right		
Left		
5k. Other Findings (if more room is needed, continue on reverse)		

		REPORT OF MEDICAL EXAM			
6. CLINICAL SCREENING (Please check if the patient has any of the following conditions and whether it will affect the ability to participate in NSCC/NLCC activities.)					
Condition(s)	Pre-Existing	NOTES: (Describe every condition in detail. Enter pertinent item number before each comment)			
6a. Seizure or convulsion disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6b. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6c. Symptomatic/recurring orthopedic injury	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6d. Diabetes, Type I	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6e. Diabetes, Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6f. Hypersensitivity to Food	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6g. Insect bites/stings sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6h. Head injuries resulting in residual impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6i. Neurological Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6j. History of recurring loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6k. History of debilitating motion sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6l. Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6m. Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No				
7. NOTES, REMARKS, AND OTHER FINDINGS (Use additional sheets of paper if needed)					
8. MEDICAL PROVIDER ENDORSEMENT (Check all that apply):					
I have reviewed the data above, reviewed the patient's medical history form and make the following recommendations for his/her participation in the NSCC/NLCC					
8a. <input type="checkbox"/> CLEARED WITHOUT RESTRICTIONS					
8b. <input type="checkbox"/> Cleared AFTER further evaluation or treatment for:					
8c. <input type="checkbox"/> Cleared for LIMITED participation					
<input type="checkbox"/> Not cleared for (specify activities): <input type="checkbox"/> Cleared only for (specify activities): Reasons:					
8d. <input type="checkbox"/> NOT CLEARED FOR PARTICIPATION					
Reasons:					
8e. <input type="checkbox"/> OTHER RECOMMENDATIONS					
<input type="checkbox"/> Recommend close monitoring during conditioning because of weight/fitness/other. <input type="checkbox"/> Recommend restrictions or monitoring of weight loss/gain or fitness concerns. <input type="checkbox"/> Recommend participation under following condition(s): <input type="checkbox"/> Other:					
9. MEDICAL PROVIDER					
9a. Name of Medical Provider (Type or Print) or Medical Provider Stamp		9b. Signature (MD, DO, NP, PA)		9c. Date (DD MMM YY)	
				w/in365 days	
9b. Medical Provider Address	9c. City	9c. State	10c. Zip Code +4	9c. Phone	

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION REPORT OF MEDICAL HISTORY	FOR OFFICIAL USE ONLY																																																																						
NOTICE																																																																								
<p>THIS DOCUMENT IS AN AUTHORIZATION, CONSENT AND RELEASE FORM. Upon enrollment, the information requested below is required to provide a medical provider an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the NSCC/NLCC training program. Also this information will be provided to a medical provider in case of injury or illness while participating in NSCC/NLCC activities. <u>If taking medications at time of enrollment, list in Block 9.</u></p> <p>THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. You are encouraged to consult your private medical provider regarding past illnesses. <u>Proof of immunization for polio, measles, mumps, rubella, hepatitis B, pertussis and tetanus plus diphtheria and Menactra vaccine for Meningitis must be attached.</u></p> <p>After enrollment, use this form to screen cadets for continued medical fitness before sending to Orientation, Recruit, Advanced and/or other trainings.</p> <p>Commanding Officers (CO) and Commanding Officers of Training Contingents (COTC) retain the obligation to deny acceptance for enrollment or training to any cadet if upon review of this form, it is determined that the cadet is not physically/medically qualified for participation unless Medical Condition and/or disability accommodation per ADA guidelines has been requested and approved.</p>																																																																								
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2m. Primary Phone	2n. Alternate Phone	2o. Date of Last Physical Examination (DD MMM YY)																																																																						
3. MEDICAL PROVIDER/INSURANCE INFORMATION																																																																								
3a. Medical Insurance Provider Name		3b. Medical Insurance Policy Number																																																																						
3c. Medical Insurance Provider Address		3d. Medical Insurance Provider Phone																																																																						
3e. Medical Provider Name		3f. Medical Provider Phone Number																																																																						
4. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 9: explain treatment to return cadet to medically fit for NSCC)																																																																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:</th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 40%;">YES</th> <th style="width: 10%;">NO</th> </tr> </thead> <tbody> <tr> <td>4a. Tuberculosis or live with someone with tuberculosis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4n. Head injury or concussion</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4b. Chronic or recurrent abdominal or stomach pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4o. Seizures, convulsions, epilepsy, or fits</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4c. Asthma or breathing problems related to exercise, pollen, etc.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4p. Car, train, sea, and/or air sickness</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4d. Been prescribed or use an inhaler</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4q. A period of unconsciousness</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4e. Loss of vision in either eye</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4r. Heart trouble or murmur</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4f. Loss of hearing or wear a hearing aid</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4s. Received counseling for emotional or behavior disorder</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4g. Impaired use of arms, legs, hands, feet</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4t. Eating disorder (bulimia, anorexia)</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4h. Knee problems</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4u. Sleepwalking</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4i. Broken bones(s) (cracked or fractured)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4v. Bedwetting</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4j. Diabetes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4w. Been hospitalized (if yes, why, when, where)</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4k. Anemia (including sickle cell)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4x. Any illness or injury not mentioned above (if yes, explain)</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4l. Dizziness or fainting spells (including after exercise)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4y. Advised to avoid certain physical activities (if yes, explain)</td> <td><input type="checkbox"/></td> </tr> <tr> <td>4m. Frequent or severe headaches</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4z. FEMALES ONLY: At what age did you begin menstrual cycle:</td> <td></td> </tr> </tbody> </table>			HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO	YES	NO	4a. Tuberculosis or live with someone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	4n. Head injury or concussion	<input type="checkbox"/>	4b. Chronic or recurrent abdominal or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	4o. Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	4c. Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	4p. Car, train, sea, and/or air sickness	<input type="checkbox"/>	4d. Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	4q. A period of unconsciousness	<input type="checkbox"/>	4e. Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	4r. Heart trouble or murmur	<input type="checkbox"/>	4f. Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	4s. Received counseling for emotional or behavior disorder	<input type="checkbox"/>	4g. Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	4t. Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	4h. Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	4u. Sleepwalking	<input type="checkbox"/>	4i. Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	4v. Bedwetting	<input type="checkbox"/>	4j. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	4w. Been hospitalized (if yes, why, when, where)	<input type="checkbox"/>	4k. 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		REPORT OF MEDICAL HISTORY			
5. IMMUNIZATION RECORDS (attach copy of immunization record to this form)					
5a. Date of last tetanus or booster		5b. Date of Menactra Vaccine for Meningitis		5c. Date of negative PPD or Medical Provider Clearance for TB	
6. ALLERGIES (Mark each item "YES" or "NO". Every item marked yes must be fully explained in Block 9.)					
DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:		YES	NO		YES NO
6a. Bee or wasp sting		<input type="checkbox"/>	<input type="checkbox"/>	6e. Latex	<input type="checkbox"/> <input type="checkbox"/>
6b. Hay Fever or seasonal allergies		<input type="checkbox"/>	<input type="checkbox"/>	6f. Any drug, e-mycin antibiotic, or sulfa allergies, list in Block 9	<input type="checkbox"/> <input type="checkbox"/>
6c. Insect bites		<input type="checkbox"/>	<input type="checkbox"/>	6g. Other allergies, list in Block 9	<input type="checkbox"/> <input type="checkbox"/>
6d. Iodine/seafood		<input type="checkbox"/>	<input type="checkbox"/>	6h. Food allergies, list in Block 9	<input type="checkbox"/> <input type="checkbox"/>
7. OVER THE COUNTER MEDICATIONS (These medications may be administered by our staff when requested)					
1. Allergies:		Benadryl			
2. Colds:		Cough Medicine (Robitussin DM, Dimetapp, etc.), Throat/Cough Drops (Chloraseptic, Halls, etc.), Decongestant (Sudafed, etc.)			
3. Constipation:		Milk of Magnesia, Dulcolax, Ex-Lax, or Glycerin Suppository			
4. Cuts and Scraps:		Bacitracin ointment, Betadine, Neosporin ointment			
5. Diarrhea:		Pepto Bismol, Kaopectate, Imodium AD, etc.			
6. Headache		Tylenol or Ibuprofen (Motrin, Advil, Aleve)			
7. Indigestion:		Calcium Carbonate (Tums, Rolaids, etc.)			
8. Itch/Rash:		Cortisone Cream or Calamine Lotion			
9. Sea/Motion Sickness:		Dramamine, Bonine, etc.			
10. Sprains:		Acetaminophen (Tylenol) or Ibuprofen (Motrin, Advil, Aleve)			
11. Sunburn:		Calamine Lotion, Topical Lidocaine Spray or Aloe Vera Gel			
12. Wounds:		Bacitracin ointments, Betadine, Neosporin Ointment			
<i>Other medications not listed above may be administered if so recommended by qualified medical staff.</i> <i>Parents will be contacted directly when over the counter medications need to be administered during unit drills</i>					
8. STATEMENT OF UNDERSTANDING AND CONSENT					Parent/Guardian
BY INITIALING YOU CERTIFY YOUR UNDERSTANDING & CONSENT TO THE FOLLOWING PARAGRAPHS:					Initial Below
8a. I understand that all medications will be administered to the cadet based on dosing instructions on the medication bottle/package. In no instance will cadets be allowed to self-medicate with any over the counter medication.					
8b. I understand and consent that these written instructions may be superseded if, in the opinion of a medical provider, not doing so would place the cadet in a medically compromised condition.					
8c. I understand that If I do not want my child to be administered over the counter medications, or certain medications concurrent with other medications, I must specify those medications or write, "Do not medicate my child with any over the counter medications" in Block 9.					
9. REMARKS (please include comments as required by Blocks 4, 6, and/or 8. Also provide any other medical history that you or your physician deems important)					
10. AUTHORIZATION AND RELEASE					
I certify that, to the best of my knowledge, the information provided is true and accurate and I have disclosed all pertinent medical history. Furthermore, I authorize the Naval Sea Cadet Corps, its agents, officials, and training staff members, to dispense medication listed on this Authorization. I "Hold Harmless" the Naval Sea Cadet Corps from any and all liability, actions, or causes of action for damages or injury that may arise, directly or indirectly, from my child's use of medication while participating in Naval Sea Cadet Corps Activities. I understand that training staff members may not be medical professionals and that medication will be dispensed according to the manufacturer's instructions and/or the instructions I provided on this authorization.					
10a. Parent/Guardian Name (Type or Print)			10b. Signature		10c. Date (DD MMM YY)



CO's TOP SIX



1. **HAZING** is any action taken or situation created to intentionally cause embarrassment, harassment, or ridicule, or to intentionally risk emotional and/or physical harm. It's still hazing even if the victim is a "willing" participant. At its core, hazing is the act of embarrassing someone primarily for the purpose of embarrassing them.
2. **BULLYING** is unwanted, aggressive behavior among peers that involves a real or perceived power imbalance. Bullying generally involves a pattern of behavior repeated over time. Bullying includes, but is not limited to, such action as: making threats, spreading rumors, assaulting someone physically or verbally, or intentionally excluding someone from a group.
3. **DISCRIMINATION** is unjustly making distinctions in the treatment of different categories of people. Prejudice is pre-judgement, bias, or partiality; it is a preconceived opinion not based on actual experience. The USNSCC is a meritocracy – here, you will be judged solely on your performance. There is a no place in the USNSCC for ignorant biases, bigotry, or pre-judgement based upon race, color, sex, gender, age, ethnicity, national origin, religion, sexual orientation, or disability.
4. **SEXUAL HARRASMENT** is a form of discrimination that involves unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature that interferes with an individual's performance, or creates an intimidating or hostile training environment. This policy is gender neutral, and applies the same way to male or females at the training. There is no place in the USNSCC for off-color jokes, teasing about sex or sexuality, inappropriate behavior in the showers, flirting, requests for dates, or any form of physical or sexual contact.
5. **FRATERNIZATION** is an unduly familiar relationship between superiors and subordinates that is prejudicial to good order and discipline. Fraternization weakens the integrity of the chain of command by creating the appearance of favoritism in our training environment.
6. **CADET TO CADET CONTACT.** Keep your hands to yourself. And no one at this training may touch you without your permission.

Cadet Signature: _____

Parent Signature: _____

US NAVAL SEA CADET CORPS
North East Florida Training Command

Rules and Regulations

- Smoking, consumption of alcohol or drug use: Is expressly forbidden for ALL cadet personnel. Possession of, use of, any of the above will result in immediate termination of training and return home at parent's/guardian's expense. Officers/instructors will not engage in smoking or drinking in the presence of cadets.
- Weapons: Do not bring any knives or other weapons to training. Either and/or both will be confiscated and not returned. Possession of, use of, any of the above will result in immediate termination of training and return home at parent's/guardian's expense.
- Inappropriate Behavior: Any cadet displaying inappropriate behavior will be returned home at parent's/guardian's expense. Inappropriate behavior is defined as any behavior that in the opinion of the Commanding Officer, that brings disfavor or maligns the image of the NSCC or any member of the NSCC in the eyes of our hosts.
- Lack of Training Motivation: Any lack of training motivation will result in counseling first and possible return home at parent's/guardian's expense. lack of training motivation is defined as failure to participate in training activities and classes and/or sleeping during training activities and classes.
- Cadet-to-Cadet Contact: There is to be NO cadet-to-cadet contact, unless it is for training purposes (under adult supervision). This includes “just joking/playing around.”
- **ALL CADETS MUST COMPLY TO ALL COVID-19 REGULATIONS ENFORCED BY THE NSCC, THE COTC(s), AND THE HOST COMMAND (ie. WEARING FACE MASK, SOCIAL DISTANCING). IF A CADET REFUSES TO ADHERE THEY WILL BE DISMISSED IMMEDIATELY. THIS IS THE ONLY RULE(s) THAT IF BROKEN, TIME OF DISMISSAL WILL NOT BE TAKEN INTO CONSIDERATION. FOR EXAMPLE, IF A CADET REFUSES TO COMPLY AT 2300, THAT IS THE TIME THEY WILL BE DISMISSED AND EXPECTED TO BE PICKED UP FROM THE TRAINING.**

- Equal Opportunity, Discrimination and Sexual Harassment: No preference will be given towards anyone regardless of color, creed, religious preference, gender or race. The command staff and other trainees will treat all cadets equally. You will be treated equally and with respect and you will be expected to treat others the same.
- No Fraternization: No males should be in female barracks; no females should be in male barracks-
- BREAKING OF ANY OR ALL OF THE CO'S "TOP" RULES CAN RESULT IN CAPTAINS MAST AND IMMEDIATE TERMINATION OF THE TRAINING
- Cell Phones: If you bring a cell phone to training, you MUST turn it in at check-in. It will!! be returned to you on the last day of training. Our preference is NO CELL PHONES AT ALL!!!!
- Enjoy your training and have fun: NSCC adult escorts will be here to help you succeed and have fun. Their primary duty is to ensure your safety and take care of any concerns or questions you may have. I certify that I have read and understand the above regulations.

NSCC Cadet Signature Date

NSCC Parent/Guardian Signature Date

NSCC Cadet PRINTED NAME Cadet Unit/Region