

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

Date: _____

I, _____, being the legal
(print parent's/guardian's full name - first name, middle initial, last name)
parent/guardian of _____, a member of
(print student's full name - first name, middle initial, last name)
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.

***NOTE: For summer leadership camps, medical insurance information is REQUIRED.
Dental insurance information is optional but may be required to obtain non-emergency dental care.

Required



His/her physician is: *	
Name:	
Address:	
Telephone (include area code):	

All Required



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

Optional

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):		
Email:		