

**Los Angeles County Sheriff's Department
Law Enforcement Explorer Program**

Application Package

Thank you for your interest in the Los Angeles County Sheriff's Department Law Enforcement Explorer Program. This packet of forms is your Application Package. This packet must be completed and turned in prior to your acceptance into the program and entrance to the Explorer Academy. Below is a checklist to guide you in completing this packet.

- Explorer Application
- Gender and Ethnicity Questionnaire
- Learning for Life Personal Health and Medical Record Part 1 and 2
- Learning for Life Personal Health and Medical Record Part 3
- Release of Liability
- Assuming Risk of Injury or Damage Agreement and Waiver and Release of Claims and Indemnity Agreement
- Authorization to Consent to Treatment of Minor (if under the age of 18)
- Copy of document that establishes Identity
- Copy of Medical Insurance Card (if applicable)
- Copy of last school report card (if currently enrolled in grade school)
- One passport size picture

**Los Angeles County Sheriff's Department
Law Enforcement Explorer Program**

Explorer Application

Last		First		Middle	
Legal Name:					
Height:	Weight:	Hair Color:	Eye Color:	Age:	
Date of Birth:		Place of Birth (City, State, Country):			
Driver's License/ Identification Card Number:			State Issued:	Expiration:	
Aliases/Nicknames:					

Number	Street	Apt #	City	State	Zip Code
Home Address:					
Home Phone:			Other Phone:		
Cell Phone/Pager:			Email:		
Name of Parent(s) or Guardian(s): (if under 18)					
Emergency Contact Name:			Emergency Contact Relationship:		
Number	Street	Apt #	City	State	Zip Code
Address:					
Emergency Contact Home Phone:			Emergency Contact Other Phone:		

School Name:		Highest Grade Completed:		GPA:	
Number	Street	Apt #	City	State	Zip Code
Address:					
Work Name:		Job Title:		Hrs. per week	
Number	Street	Apt #	City	State	Zip Code
Address:					
Work Phone:		Supervisor:			

I understand that any portion of this application is subject to examination by the Los Angeles County Sheriff's Department. I acknowledge that all the information contained will be used solely for the Law Enforcement Explorer Program and for no other purposes. All of the information in this application is correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____

Signature of Parent/Guardian (if under 18): _____ Date: _____



Personal Health and Medical Record

Part I and Part 2

Part 1 (update annually for all participants). Activity: camping, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

Part 2 (required once every 36 months for all participants under 40 years of age). Activity: Camping or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

Note: Some states require an **annual** medical evaluation. Your Learning for Life representative can advise you about the requirements for your state.

If your child has had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Part 2 section of this form) must be scheduled by a licensed health-care practitioner*. This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past six months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for Learning for Life purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice. **THIS FORM IS NOT TO BE USED BY ADULTS OVER 40.**

Part 1 Personal Health and Medical History

(To be filled out annually by all participants)

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

I give permission for full participation in Learning for Life programs, subject to limitations noted herein. In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____

Some hospitals require the parent/guardian signature to be notarized.

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No Explain: _____

GENERAL INFORMATION:

	Yes	No		Yes	No		Yes	No
ADHD (attention deficit hyperactivity disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

List any medications to be taken during activity: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations (Give date of last inoculation.):

Tetanus toxoid _____ Measles _____ Polio _____
 Diphtheria _____ Mumps _____
 Pertussis _____ Rubella _____

Part 2 Medical Evaluation

(Read additional requirements outlined on front of form.)

Name _____ Age _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ / _____ Pulse _____

Lab: Urinalysis (dipstick) _____ Albumin _____ Sugar _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Limitations

Activity restrictions _____

Diet restrictions _____

Signature (Licensed health-care practitioner*) _____ Date _____

Address _____ Phone _____

City, State, Zip _____

Examinations conducted by licensed health-care practitioners other than physicians will be recognized for Learning for Life purposes where such practitioners may perform physical examinations within their legally prescribed scope of practice.

INTERVAL	SCREENING EXAMINATION	
Date, time, place, etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By

PHOTOCOPYING THIS FORM IS PERMITTED.

Learning for Life Personal Health and Medical Record Form—Part 3

All Part 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition, etc.

Religious preference _____

I. IDENTIFICATION

Age _____ Sex _____ Date of Birth _____

Name (Last, First, MI) _____

Address _____

City, State, Zip _____

Health/Accident Insurance _____ Policy No. _____

In an Emergency, Notify:

Name _____ Relationship _____

Address _____

City, State Zip _____

Home Phone _____ Business Phone _____

Personal Physician _____ Phone _____

II. EMERGENCY MEDICAL INFORMATION

Applicant has or is subject to (check and give details):

- Allergy to a medicine, food, plant, animal, or insect toxin
- Any condition that may require special care, medication, or diet
- ADHD (attention deficit hyperactivity disorder)
- Asthma Convulsions Heart trouble Contact lenses
- Diabetes Fainting spells Bleeding disorders Dentures

EXPLAIN _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? Yes No

Does applicant take medicine regularly or have special care? No Yes If yes, explain: _____

To be best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in Learning for Life programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian (Must sign if applicant is 18 or younger) _____

Applicant's signature _____ Date signed _____

IV. IMMUNIZATIONS

If disease, put "D" and year. (Note: LYG indicates "last year given.")

Tetanus	LYG	Diphtheria	LYG	Pertussis	LYG	Measles	LYG
Mumps	_____	Rubella	_____	Polio	_____	Chicken pox	_____

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in: Hiking and camping Competitive sports Water activities All activities

Specify exceptions _____

Recommendations (explain any restrictions OR limitations): _____

Signed by licensed health-care practitioner* _____ Date _____

*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for Learning for Life purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

VI. MEDICAL HISTORY Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI before seeing a licensed health-care practitioner. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

Date of most recent complete physical examination (month and year) _____

Are you aware of any current health problems? _____ No _____ Yes

Now under medical care or taking medicines? _____ No _____ Yes

Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination?

_____ No _____ Yes

Give dates and full details below for any "yes" answers. IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	NO	YES	YEAR	DETAILS/MEDICINES
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____
Deformity	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Skin, glands	_____	_____	_____	_____
Ears, eyes	_____	_____	_____	_____
Nose, sinus	_____	_____	_____	_____
Teeth, tonsils	_____	_____	_____	_____
Dentures	_____	_____	_____	_____
Bridge	_____	_____	_____	_____
Chest, lungs	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Murmur	_____	_____	_____	_____
Rheumatic fever	_____	_____	_____	_____
Stomach, bowels	_____	_____	_____	_____
Appendicitis	_____	_____	_____	_____
Kidneys or urine	_____	_____	_____	_____
Albumin	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Infection	_____	_____	_____	_____
Bed-wetting	_____	_____	_____	_____
Menstrual problems	_____	_____	_____	_____
Hernia (rupture)	_____	_____	_____	_____
Back, limbs, joints	_____	_____	_____	_____
Sleepwalking	_____	_____	_____	_____
Nervous condition	_____	_____	_____	_____
Other (explain)	_____	_____	_____	_____

VII. HEALTH EXAMINATION Licensed Health-Care Practitioner

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afloat or afoot) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, and sign.

Date _____	VISION	HEARING
Ht. _____ Wt. _____	Normal _____	Normal _____
B.P. ____ / ____ Pulse _____	Glasses _____	Abnormal _____
	Contacts _____	

Check if normal; circle if abnormal and give details below:

_____ Growth, development	_____ Teeth, tonsils	_____ Genitourinary
_____ Skin, glands, hair	_____ Respiratory	_____ Skeletomuscular
_____ Head, neck, thyroid	_____ Cardiovascular	_____ Neuropsychiatric
_____ Eyes, ears, nose	_____ Abdomen, hernia	_____ Other (specify)

COMMENTS _____

LABORATORY: Urinalysis (dipstick) Albumin _____ Sugar _____

REVIEW FOR CAMP OR SPECIAL ACTIVITY

DATE	AGENCY OR ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD (CAMP, SPORTS ACTIVITIES, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENTS, INSTRUCTIONS, DISPOSITION, ETC.	BY



County of Los Angeles Sheriff's Department
Law Enforcement Explorer Program
11515 S. Colima Road, A100
Whittier, California 90604



Assuming Risk of Injury or Damage Agreement and
Waiver and Release of Claims and Indemnity Agreement

WHEREAS, I, _____ (being/not being) over the age of eighteen and not being a member of the Sheriff's Department of the County of Los Angeles, have made a voluntary request to ride as a guest in a vehicle assigned to the Los Angeles County Sheriff's Department and to accompany a member or members of the Sheriff's Department during the performance of their official duties, and

WHEREAS, the Sheriff's Department of the County of Los Angeles is willing to allow me to ride as a guest in a vehicle assigned to that department and to accompany a member or members of the department during the performance of their duties on the following conditions:

NOW, THEREFORE, in consideration of the permission given to me to ride in a vehicle assigned to the Sheriff's Department of Los Angeles County and to accompany a member or members of said department during the performance of their official duties, I do hereby agree:

1. That I am aware that the work of the Sheriff's Department is inherently dangerous and that I may be subjected to the risk of death or personal injury or damage to my property by accompanying a member or members of the Sheriff's Department during the performance of their official duties, and that I feely, voluntarily, and with such knowledge, assume the risk of death, personal injury, or property damage, arising from or in any way connected with the use of weapons, unlawful acts of forcible resistance by law violators or suspected law violators, assaults, riots, breaches of the peace, fires, explosions, gas, electrocution, or the escape of radioactive substances while accompanying a member or members of the Sheriff's Department during the performance of their official duties.
2. That the Los Angeles County Sheriff's Department, Leroy Baca, Sheriff of the County of Los Angeles, his sureties, all members of the Sheriff's Department of Los Angeles County, their sureties, and each of them, shall not be responsible or liable for any injury, damage, loss or expense, either to me or my property, incurred while riding in any vehicle assigned to the Los Angeles County Sheriff's Department or while accompanying any member or members of said department during the performance of their official duties and resulting from any negligent act or omission on the part of any member of the Los Angeles County Sheriff's Department.
3. For myself, my heirs, executors, administrators, and assigns to defend and indemnify the County of Los Angeles, Leroy Baca, Sheriff of Los Angeles County, all members of the Los Angeles County Sheriff's Department, their sureties and each of them, against any and all manners of actions, causes of actions, suits, debts, claims, demands, or damages or liability or expense of every kind and nature, incurred or arising by reason of any actual or claimed negligent or wrongful act or omission of mine while riding in any vehicle assigned to the County of Los Angeles Sheriff's Department or while accompanying any member or members of the said Sheriff's Department during the performance of their official duties.

A Tradition of Service

Documents that Establish Identity

Please provide a copy of **one** of the following:

1. United States Passport (unexpired or expired)
2. Driver's License or Identification Card issued by a state or outlying possession of the United States, provided that it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
3. Identification Card issued by federal, state, or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
4. School Identification Card with a photograph
5. Military Dependent's Identification Card
6. Native American Tribal Document

Misc. Attachments

Please provide the following:

1. Copy of Medical Insurance Card (if applicable)
2. Copy of last school report card (if currently enrolled in grade school)
3. One passport size picture