



SENIOR FORMS CHECKLIST

All forms below need to be completed

- CAPF-17
- CAPF-160
- CAPF-161
- Senior Member applications must additionally provide a copy of their current First Aid and/or CPR card

LIMITED SPACES

DEADLINES:

Staff cutoff is Nov 1, 2017

Open to other states - November 1, 2017

CEAP is open - November 1, 2017

Final cutoff for attendance - December 10, 2017

Submit to your Commander or Deputy Commander before the deadline. Ask about your Squadron's deadlines.

*Out-of-state applicants - please send to
SMSgt Cory Felts
6919 Glen Lily Road
Bowling Green KY 42101*

KYWG Winter Encampment 2018 Packing List

December 27th 2017 to January 1st 2018

Ensure you read the packing list in its entirety and bring all listed items. Use the check lines on the left to ensure you have packed everything. There is not a store available to purchase any of these items on site. ALL items, including clothing, toiletries, and miscellaneous gear is to have last name, first initial, and CAPID written on it.

Clothing & Uniforms

- ___ 1 Sort Sleeve Blues shirt (complete with insignia, ribbons, name plate)
- ___ 1 Blues slacks or skirt (slacks preferred)
- ___ 1 flight cap w/ device
- ___ 1 Blues belt w/chrome buckle and tip
- ___ 1 pair uniform shoes (black low quarters)
- ___ 2 or more white v-neck tee shirts
- ___ 2 pair dress socks, black
- ___ 2 pair neutral shade hose (w/female skirt)
- ___ 1 USAF Regulation Tie (males) or Tie Tab (females)
- ___ 2 BDU/ABU blouse with all required tapes & insignia
- ___ 2 BDU/ABU pants
- ___ 1 BDU/ABU belt, USAF blue w/ black buckle/tip, black riggers belt -OR- Tan Belt (ABU's)
- ___ 1 pair uniform boots, WELL BROKEN IN
- ___ 1 set blousing bands (for BDU pants)
- ___ 5 black tee shirts (plain/BDU's) or 5 tan tee shirts (ABU's)
- ___ 1 BDU/ABU cover, USAF Style (THIS IS THE ONLY APPROVED HEADGEAR)
- ___ 1 military-style canteen with web belt -OR- hydration pack (Camelback-style)
- ___ 1 sweatshirt (black no logos are authorized)
- ___ 5 pair Boot socks (black for BDU's or green for ABU's)
- ___ CAP membership card – must carry with you at all times
- ___ CAPF-160 Emergency Contact—must carry with you at all times
- ___ 1 pair gym shoes
- ___ 5 set of underwear
- ___ 5 pair athletic socks
- ___ 3 pairs gym shorts, BLACK ONLY
- ___ 3 grey t-shirts (plain, no lettering)
- ___ 1 Reflective Belt/Vest
- ___ 1 laundry bag

Medical & Hygiene

- ___ 10 day supply of all personal medications
- ___ Moleskin padding (optional)
- ___ 2 bath towels, 2 wash cloths,
- ___ Soap, shampoo
- ___ 1 pair shower shoes
- ___ 1 comb and/or brush
- ___ Toothbrush and toothpaste
- ___ Deodorant – Febreze also recommended for clothing
- ___ Feminine hygiene products as appropriate

Additional Items

- ___ 24 hr gear (Senior/Cadet Staff and Advanced Training Flight Only)
- ___ 1 pocket-sized notebook, a 6" ruler, 3 pencils
- ___ Shoe shine kit
- ___ Cotton Balls
- ___ Sleeping bag
- ___ Pillow

Contraband Items:

- Anything NOT on the above list
- Electronic devices of any kind
- Time-keeping device (watch or alarm clock)
- Playing cards
- Non-religious reading material
- Any illegal substance, alcohol, tobacco, e-cig, vapor products
- All knives, lighters, matches (Senior/Cadet Staff and Advanced Training Flight may have 1 set of matches in 24 hr gear)
- Weapons of any kind
- Any food or drinks

All contraband items (including cell phones) must be turned in at check in for both sessions. These items will be sealed in an envelope, and returned to the cadet at check out.

Proper conduct is expected from all participants at all times, and persons not complying with the rules of the camp will be sent home at their own expense.

//////SIGNED//////

MICHAEL C. FELTS, SMSgt, CAP
Director of Cadet Programs
GLR-KY-001

APPLICATION FOR SENIOR MEMBER ACTIVITIES

Note: Use of this form is optional (see CAPR 50-17, para 2-7b2). See instructions on reverse.

1. Title of Activity (If applying for a position, include the position desired)		2. Location of Activity	
3. Dates of Activity		4. Previously Attended This Activity? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, give date)	
5. Last Name, First, Middle Initial		6. CAP Grade	7. CAPID
8. Member's Address (Include No., Street, City, State, Zip) _____ _____ _____		9. Telephone (Include Area Code)	
		Work () _____	
		Home () _____ E-Mail _____	
10. Charter Number	11. Unit Name	12. Date of Level I Completion	
13. Date Joined CAP	14. CAP Duty Assignment and Inclusive Dates	15. CAP Aeronautical Rating	
16. Specialties and Ratings Completed		17. Previous Training Activities and Years Attended	
Specialty	Rating		
a. _____	_____	a. _____	
b. _____	_____	b. _____	
c. _____	_____	c. _____	
d. _____	_____	d. _____	
		e. _____	
18. Professional Development Awards		19. Scholastic Achievement	
a. _____		High School Graduate (Year):	
b. _____		College (Number of Years):	
c. _____		Post Graduate (Number of Years):	
d. _____			
20. Civilian Occupation		21. Emergency Medical Information	
22. Outline Personal and Professional Goals in CAP			
23. Remarks (Use Reverse Side or Attach Additional Sheet if Necessary)		Applicant's Signature and Date	
24. Unit Commander (if required) Recommend <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval Remarks:		Unit Commander's Signature and Date	
25. Wing Commander (if required) Recommend <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval Remarks:		Wing Commander's Signature and Date	
26. Region Commander (if required) Region Selection Number Recommend <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval Remarks:		Region Commander's Signature and Date	

27. Additional Remarks:

INSTRUCTION FOR COMPLETION OF CAP FORM 17

NOTE: Use of this form is optional at the discretion of the activity director (see CAPR 50-17, para 2-7b2).

See CAPR 50-17, *CAP Senior Member Professional Development Program*, for additional information and instructions.

1. APPLYING FOR ACTIVITIES:

a. For region level activities, unit commander verifies the information, makes recommendation, signs the application, retains a copy, and forwards the original to wing headquarters. Wing commander verifies application, makes recommendation, signs the application, retains a copy, and forwards the original to region headquarters for final approval by region commander.

b. For selected national level activities, unit commander verifies the information, makes recommendation, signs the application, retains a copy, and forwards the original to wing headquarters. Wing commander verifies application, makes recommendation, signs the application, retains a copy, and forwards the original to region headquarters for action (if applicable). Region commander makes recommendation, assigns selection number, signs the application, retains a copy, and forwards original to NHQ CAP/PD.

2. COMPLETING THE FORM:

Blocks 1-11, 13-15, 19-20 are self explanatory.

Block 12. Enter the month and year of Level I completion. (Example: Feb 92)

Block 16. List each specialty and the highest rating completed in that specialty. (Example: Enter 213-2 for Emergency Services Officer - Senior Level, or enter 201-1 for Public Affairs - Technician Level.)

Block 17. List names and dates of training activities such as SAR exercises, SLS, AFIADL Course-13, RSC, ACSC, AWC, etc. Use Additional Remarks section above or add additional sheet if necessary.

Block 18. List training awards only along with completion dates. (Example: Garber Award Aug 90.)

Block 21. List physical handicaps or ailments for which the applicant will be taking medication during the activity or which might affect the applicant's level of participation in activities. Provide a list of medication taken regularly. Use Additional Remarks section or add additional sheet if necessary.

Block 24. For Unit Commander.

Remarks are intended for consideration by the wing commander. Use Additional Remarks section or add additional sheet if necessary.

Block 25. For Wing Commander.

For National Staff College (NSC), wing commander approves for personnel assigned within their wing, then forwards to NHQ CAP/ETP. Use Additional Remarks section or add additional sheet if necessary.

Block 26. For Region Commander.

For National Staff College (NSC), this block is completed by region commander only for those members currently serving on the region staff, and then forwarded to NHQ CAP/PD. Remarks are intended for consideration by National Headquarters. Use Additional Remarks section or add additional sheet if necessary.

CAP MEMBER HEALTH HISTORY FORM

This information is CONFIDENTIAL and for official use only. It cannot be released to unauthorized persons. Answer all questions as accurately as possible so that the activity or encampment staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you. This form will also provide medical information in a case when you are unable to do so.

Name <i>(Last, First, Middle)</i>			Grade	CAPID	Charter Number
Date of Birth	Height	Weight	Hair Color	Eye Color	Gender

Allergies: List Names of Medication or Other Allergies (*i.e., bee sting, food, plants*) and types of reactions; please note food allergy details with dietary restrictions below on back as well.

Do You Now Have Or Have You Ever Had Any Of The Following? *Explain any yes' in the remarks section below or attach additional sheet. Conditions not specifically noted below having the potential to interfere with performance during the special activity or encampment should be documented in the remarks section.)*

If "Yes" is marked in an item with multiple choices, please circle which problem applies.

No	Yes		No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Decreased vision, glaucoma, contacts	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurring injuries
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections, perforation	<input type="checkbox"/>	<input type="checkbox"/>	Activity, mobility restrictions
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty equalizing ears	<input type="checkbox"/>	<input type="checkbox"/>	Use of cane, walker, wheelchair
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss, hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Back or neck pain or injury
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	Migraine or severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis, serious allergic reaction	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, emphysema (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Head injury, unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	Ever use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizure
<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath with activity	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, chest pain, angina	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems (low or high)
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur, heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, high or low blood sugars
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Irregular or rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease, hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness
<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble, ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Special diet, food allergies
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Current bedwetting problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea, constipation	<input type="checkbox"/>	<input type="checkbox"/>	ADD (Attention Deficit Disorder)
<input type="checkbox"/>	<input type="checkbox"/>	Hernia or rupture	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness (bipolar, other)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression, anxiety, suicidal
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems (men)	<input type="checkbox"/>	<input type="checkbox"/>	Admission to the hospital
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Other chronic medical illnesses
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps (women)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder, sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	Broken bone, joint problems	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury

Dietary Restrictions or Limitations (*List any dietary restrictions like food allergies, diabetes, gluten-free, vegetarian diets, etc.*)

Past Surgical History (*List all surgeries including tonsils, ear tubes, appendix, gall bladder, hernia, hysterectomy, heart, heart catheterization, bone and joint and all other surgeries.*)

Date Tetanus Booster
 No Td or Tdap
 Date:

Hepatitis Vaccine
 No
 Date:

Pneumonia Vaccine
 No
 Date:

Varicella Immunization/chickenpox
 No
 Date:

Influenza Vaccine
 No
 Date:

Medication Information - *Include supplements, over-the-counter medicines, herbals, creams, etc., or write "None".*

Name of Medication/Inhaler	Tablet Strength	Times taken per day	Reason for Medication	Any Special Dosing or Storage Instructions (i.e., as needed, with meals, must be refrigerated, etc.)
1.				
2.				
3.				
4.				

Social History

Tobacco Use (*packs per day, years smoked, smokeless tobacco use*)

Occupation (*student or other*)

Religious Preference

Remarks (*Attach additional sheet if needed*)

CONSENT FOR MINOR CADET PARTICIPATION, MEDICATIONS, TREATMENT

I give permission for full participation in CAP programs, subject to any limitations noted herein.

My signature below evidences my consent for my child/ward to possess and self-administer the prescription medications listed above. I understand that there are legal limitations imposed on CAP senior members with regard to the involuntary administration of medications to my child/ward. (Cross out if permission is denied).

In case of emergency, I understand every effort will be made to contact me. 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. Medical providers are authorized to disclose to the adult in charge exam/test results and treatment provided.

DATE

SIGNATURE OF PARENT/GUARDIAN

EMERGENCY INFORMATION (Insurance/Physician Information, Emergency Contacts, Minor Consents)				
Name <i>(Last, First, Middle)</i>		Grade	CAPID	Charter Number
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
<i>(Area Code)</i> Home Phone		<i>(Area Code)</i> Cell Phone		
Primary Insurance Information <i>(Please attach copy of insurance cards, front and back)</i>				
Medical Insurance Company		Policy Number	Group Code/Number	Co-Pay Amount \$
Prescription Coverage Company		Policy Number	Group Code/Number	Co-Pay Amount \$
Family Physician				
Name			<i>(Area Code)</i> Phone	
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
Emergency Contact <i>(Parent, guardian or closest relative to be notified in case of emergency)</i>				
Name			Relationship to Applicant	
Mailing Address <i>(Number and Street)</i>		City	State	Zip Code
<i>(Area Code)</i> Pager	<i>(Area Code)</i> Cell/Mobile Phone	<i>(Area Code)</i> Day Phone	<i>(Area Code)</i> Night Phone	
Unit Commander Name and Grade		Unit Name		
<i>(Area Code)</i> Unit Commander Day Phone		<i>(Area Code)</i> Unit Commander Night Phone		