



**NEW YORK CITY DEPARTMENT OF CORRECTION**  
**CORRECTION YOUTH EXPLORER PROGRAM POST#0072**

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The mission of the NYC Department of Correction Youth Explorer Post is to foster leadership and self-development within it's' participants. The goal of the program is to provide an understanding and knowledge of the Department of Correction and other law enforcement agencies. The Explorers will become leaders in their communities and gain comprehension for law and law enforcement.

Eligibility Requirements:

- 14-20 years old
- Enrolled in a high school
- Not enrolled in another Explorer post
- A good student with a minimum grade point average of 2.0 or a 70% average and have regular attendance.
- Be willing to actively participate in community service activities.

The application packet contains the following documents: A Learning for Life Application, P.A.L. Application and a multimedia consent form. By becoming a DOC Youth Explorer, you will also become a member of the Police Athletic League. Upon submission of the application, please provide the following documents:

1. Copy of your last report card
2. Teacher or guidance counselor recommendation
3. Copy of your school ID

If you have any questions about the application or the DOC Youth Explorers program, please contact [youthexplorers@doc.nyc.gov](mailto:youthexplorers@doc.nyc.gov).





# Explorer Club

## For Sixth-, Seventh-, and Eighth-Graders

The Explorer Club Learning for Life career education program is for young men and women who are in the sixth, seventh, and eighth grades.

The Explorer Club's purpose is to provide experiences to help young people learn about different careers.



The Exploring Learning for Life career education program is for young men and women who are at least 14 (and have completed the eighth grade) or 15 years of age but not yet 21 years old.

Exploring's purpose is to provide experiences to help young people mature and become responsible and caring adults. Explorers are ready to explore the meaning of interdependence in their personal relationships.

## YOUTH APPLICATION

Exploring is based on a unique and dynamic relationship between youth and the organizations in their communities. Local community organizations initiate a specific Explorer post or club by matching their people and program resources to the interests of young people in the community. The result is a program of activities that helps youth pursue their special interests, grow, and develop.

Explorer posts/clubs can specialize in a variety of career skills. Exploring programs are based upon five areas of emphasis: career opportunities, life skills, citizenship, character education, and leadership experience.





## Learning for Life and Exploring Annual Health and Medical Record

(Valid for 12 calendar months)

### Policy on Use of the Learning for Life and Exploring Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, Learning for Life recommends that everyone who participates in a Learning for Life or Exploring event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this form will help ensure you meet the minimum standards for participation in various activities. Note that adult leaders must always protect the privacy of unit participants by protecting their medical information.

**Parts A and B** are to be completed at least annually by participants in all Learning for Life and Exploring events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

**Part C** is the physical exam that is required for participants in any event that exceeds 72 consecutive hours or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed health-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the post/club/group more than 30 minutes away from an emergency vehicle or an accessible roadway, or to remote areas.

### Risk Factors

Based on the vast experience of the medical community, Learning for Life has identified that the following risk factors may define your participation in various outdoor activities.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

For more information on medical risk factors, visit the Safety First Guidelines on [www.learningforlife.org](http://www.learningforlife.org).

### Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. An adult leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but Learning for Life does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

# Part A: Informed Consent, Release Agreement, and Authorization

Full name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Outing participants:**

Post/club/group No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

## Informed Consent, Release Agreement, and Authorization

I understand that participation in Learning for Life activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Learning for Life, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with Learning for Life volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Learning for Life activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

## ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS

You must designate at least one adult. Please include a telephone number.

1. Name \_\_\_\_\_ Telephone \_\_\_\_\_

2. Name \_\_\_\_\_ Telephone \_\_\_\_\_

3. Name \_\_\_\_\_ Telephone \_\_\_\_\_

Adults NOT authorized to take youth to and from events:

1. Name \_\_\_\_\_

2. Name \_\_\_\_\_

3. Name \_\_\_\_\_

**I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.**

Participant's name: \_\_\_\_\_ Date: \_\_\_\_\_

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If participant is under the age of 18)

Second parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If required; for example, CA)

**This Annual Health and Medical Record is valid for 12 calendar months.**



# Part B: General Information/Health History

Full name: \_\_\_\_\_

**Outing participants:**  
 Post/club/group No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Post/club/group leader: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Council Name/No.: \_\_\_\_\_ Post/club/group No.: \_\_\_\_\_

Health/Accident Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_

**! Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above. !**

**In case of emergency, notify the person below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Alternate contact name: \_\_\_\_\_ Alternate's phone: \_\_\_\_\_

## Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date:
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Last attack date:
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eye/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last seizure date:
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date:
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

## Part B: General Information/Health History

Full name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Outing participants:**  
 Post/club/group No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

### Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.  IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

YES  NO Non-prescription medication administration is authorized with these exceptions: \_\_\_\_\_

Administration of the above medications is approved for youth by: \_\_\_\_\_

Parent/guardian signature

MD/DO, NP, or PA signature (if your state requires signature)



**Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.**



### Immunization

The following immunizations are recommended by Learning for Life. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	immunization	Dates:
<input type="checkbox"/>	<input type="checkbox"/>		Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>		Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>		Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>		Measles/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>		Polio	
<input type="checkbox"/>	<input type="checkbox"/>		Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>		Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>		Influenza	
<input type="checkbox"/>	<input type="checkbox"/>		Other (i.e., Hib)	
<input type="checkbox"/>	<input type="checkbox"/>		Exemption to immunizations (form required)	

Please list any additional information about your medical history:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DO NOT WRITE IN THIS BOX**  
 Review for program or special activity.

Reviewed by: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Further approval required:  Yes  No  
 Reason: \_\_\_\_\_  
 Approved by: \_\_\_\_\_  
 Date: \_\_\_\_\_

# Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Outing participants:**

Post/club/group No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

**! You are being asked to certify that this individual has no contraindication for participation in a Learning for Life or Exploring experience. !**

**Examiner: Please fill in the following information:**

		Yes	No	Explain
Medical restrictions to participate		<input type="checkbox"/>	<input type="checkbox"/>	
Yes	No	Allergies or Reactions		Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		
<input type="checkbox"/>	<input type="checkbox"/>	Food		
Yes	No	Allergies or Reactions		Explain
<input type="checkbox"/>	<input type="checkbox"/>	Plants		
<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings		

Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

	Normal	Abnormal	Explain Abnormalities
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia/hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

## Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Learning for Life and/or Exploring experience. This participant (with noted restrictions):

True	False	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Meets height/weight requirements.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have uncontrolled heart disease, asthma, or hypertension.
<input type="checkbox"/>	<input type="checkbox"/>	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled psychiatric disorders.
<input type="checkbox"/>	<input type="checkbox"/>	Has had no seizures in the last year.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have poorly controlled diabetes.
<input type="checkbox"/>	<input type="checkbox"/>	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider printed name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Office phone: \_\_\_\_\_

### Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned program or special activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

#### Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
80	166	85	196	70	226	75	260
81	172	86	201	71	233	76	267
82	178	87	207	72	239	77	274
83	183	88	214	73	246	78	281
84	189	89	220	74	252	79 and over	296



Consent to Photograph, Film or Videotape a Visitor for Non-Profit Use

Name of Visitor: \_\_\_\_\_

I hereby consent to the participation in interviews, the use of quotes, the taking of photographs, movies or videotapes.

I also grant the New York City Department of Correction the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet and all forms of social media. I also hereby release the New York City Department of Correction and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

If under 18 years of age:

I am a parent or guardian of the above minor, and I hereby agree to the above terms on his/her behalf.

Name of Parent/Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

If over 18 years of age:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_