Dinuba Police Explorers, Post 325
680 S. Alta Avenue, Dinuba, CA. 93618
Telephone (559) 591-5914 Fax (559) 591-5920

L.E.E.P. #07

"APPLICATION FOR MEMBERSHIP"

NAME: _____
(Last) (First) (Middle)

ADDRESS: _____ _____ _____ _____
(City) (State) (Zip Code)

AGE: _____ DATE OF BIRTH: _____ _____, _____
(Month) (Day) (Year)

HOME TELEPHONE NUMBER: _____ _____
(A/C) (Number)

MEMBERSHIP REQUIREMENTS:

1. Applicant must be 14 to 21 years of age.
2. Applicant must have parental permission, which includes signatures of explorer, parent(s) or guardian and a general liability form.
3. Applicant must be in good health.
4. Applicant must be of good moral habits, to include no arrest record or conviction for serious offenses.
5. Applicant will be subject to a background check.
6. Applicant must maintain a passing grade in all school classes.
7. Applicant must display good citizenship at all times.
8. Applicant must maintain a clean and neat appearance at all times.

_____ _____ _____ _____
(Parent/Guardian Signature) (Date) (Applicant Signature) (Date)

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TO: POST ADVISOR
EXPLORER POST #325

SUBJECT: LETTER OF APPROVAL

I (we) give consent for _____ to become an active
(Name First, Last)

member of the Dinuba Police Explorer Program sponsored by the Dinuba Police Department. I (we) understand that an investigation may be conducted to determine moral character, police record, driving record and scholastic record. The results of this investigation may result in non-selection to participate in the Police Explorer Program.

_____ _____
(Signature of Parent or Guardian) (Date)

_____ _____
(Signature of Parent or Guardian) (Date)

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PERSONAL HISTORY FORM

(TYPE OR PRINT LEGIBLY)

NAME: _____
(LAST) (FIRST) (MIDDLE OR INITIAL)

ADDRESS: _____ _____ _____ _____
(NUMBER) (STREET) (CITY) (ZIP)

TELEPHONE NO. ____ _____ AGE: _____ DATE OF BIRTH: _____

HEIGHT: ____ WEIGHT: ____ HAIR COLOR: ____ COLOR OF EYES: ____

SCHOOL ATTENDING: _____

PRINCIPAL'S NAME: _____

ORGANIZATION OR
CLUB MEMBERSHIP: _____ _____
(NAME OR TITLE) (LOCATION)

_____ _____
(NAME OR TITLE) (LOCATION)

_____ _____
(NAME OR TITLE) (LOCATION)

FATHERS NAME: _____ MOTHERS NAME: _____

PARENT(S) ADDRESS: (IF DIFFERENT) _____ _____
(NUMBER AND STREET) (CITY)

FATHERS OCCUPATION: _____ _____
(TITLE OR JOB) (WORK PHONE NUMBER)

MOTHERS OCCUPATION: _____ _____
(TITLE OR JOB) (WORK PHONE NUMBER)

GUARDIAN NAME: _____ _____
(TELEPHONE NUMBER)

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GUARDIAN ADDRESS: _____ _____ _____
(NUMBER AND STREET) (CITY) (ZIP)

BROTHER(S): _____ _____ _____ _____
(NAME) (AGE) (NAME) (AGE)

_____ _____ _____ _____
(NAME) (AGE) (NAME) (AGE)

SISTER(S): _____ _____ _____ _____
(NAME) (AGE) (NAME) (AGE)

_____ _____ _____ _____
(NAME) (AGE) (NAME) (AGE)

CLOSET RELATIVE NOT LIVING WITH YOU: _____
(NAME)

ADDRESS: _____ _____ _____
(NUMBER AND STREET) (CITY) (ZIP)

RELATIONSHIP: _____ PHONE NUMBER _____

FAMILY PHYSICIAN: _____ PHONE NUMBER _____
(NAME)

ADDRESS: _____ _____ _____
(NUMBER AND STREET) (CITY) (ZIP)

HOSPITAL PREFERENCE: _____ _____
(NAME) (CITY)

IS ANY MEMBER OF YOUR FAMILY ASSOCIATED WITH LAW ENFORCEMENT? ___YES ___NO (IF YES, PLEASE GIVE NAME, POSITION AND AGENCY.) _____ _____
(NAME) (POSITION)

_____
(NAME OF AGENCY)

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PERSONAL HISTORY FORM
CONTINUED

PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

(EXPLAIN ALL YES ANSWERS IN THE SPACE PROVIDED UNDER "REMARKS".)

HAVE YOU EVER BEEN ARRESTED? __YES __NO

HAVE YOU EVER RECEIVED A TRAFFIC CITATION? __YES __NO

DO YOU SUFFER FROM A MENTAL/PHYSICAL DISORDER? __YES __NO

HAVE YOU BEEN HOSPITALIZED DURING THE LAST THREE YEARS?__YES__NO

ARE YOU OR HAVE YOU EVER BEEN A MEMBER OF THE BOY SCOUTS OR GIRL SCOUTS OF AMERICA? __YES __NO

REMARKS:_____

_____

_____

SCHOOL

WHAT IS YOUR GRADE AVERAGE IN SCHOOL?_____

WHAT IS YOUR FAVORITE SUBJECT?_____

WHY?_____

WHAT SUBJECT DO YOU DISLIKE?_____

WHY?_____

WHAT DO YOU LIKE ABOUT SCHOOL?_____

DO YOU PLAN TO GO TO COLLEGE?__YES __NO IF YES, WHERE?_____

WHAT ARE YOUR FAVORITE SPORTS? _____,_____,_____

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EMPLOYMENT INFORMATION

ARE YOU EMPLOYED? ___YES ___NO ___FULL-TIME ___PART-TIME

DUTIES:_____

NAME OF EMPLOYER:_____

ADDRESS:_____ _____ _____
(NUMBER AND STREET) (CITY) (ZIP)

PHONE NUMBER:_____ _____
(A/C)

GENERAL INFORMATION

DO YOU HAVE A CALIFORNIA DRIVERS LICENSE? ___YES ___NO
(IF YES, WHAT IS YOUR DRIVERS LICENSE NUMBER:_____)

WHAT ARE YOUR HOBBIES?_____

_____

I, _____, UNDERSTAND THAT ANY PORTION OF THIS FORM
(APPLICANT NAME)
IS SUBJECT TO EXAMINATION BY THE DINUBA POLICE DEPARTMENT. I FURTHER ACKNOWLEDGE THAT ALL THE INFORMATION CONTAINED HEREIN WILL BE USED SOLELY FOR THE EXPLORER PROGRAM OF THE DINUBA POLICE DEPARTMENT.

I, CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____ _____
(SIGNATURE OF APPLICANT) (DATE) (SIGNATURE OF PARENT/GUARDIAN) (DATE)

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"AUTHORIZATION FOR MEDICAL TREATMENT"

TO: POST ADVISOR (ADULT IN CHARGE)
EXPLORER POST #325

SUBJECT: AUTHORIZATION TO OBTAIN MEDICAL TREATMENT

IF DURING THE COURSE OF _____
(NAME FIRST, LAST)
ACTIVITIES WITH THE DINUBA POLICE EXPLORER POST, AN ACCIDENT OR INJURY SHOULD RESULT, I HEREBY AUTHORIZE THE ADULT IN CHARGE TO OBTAIN EMERGENCY MEDICAL CARE.

_____ _____
(SIGNATURE OF PARENT OR GUARDIAN) (DATE)

- -

I DO NOT AUTHORIZE EMERGENCY MEDICAL CARE FOR_____
(NAME FIRST, LAST)
BELOW IS THE ACTION I WANT TAKEN SHOULD AN EMERGENCY ARISE:

_____

_____

_____ _____ _____
(SIGNATURE OF PARENT OR GUARDIAN) (PHONE NO.) (DATE)

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HEALTH HISTORY FORM

(TYPE OR PRINT LEGIBLY)

THIS FORM TO BE FILLED OUT BY PARENT AND RETURNED WITH APPLICATION FORM.

NAME:_____ AGE:_____
(LAST) (FIRST) (MIDDLE OR INITIAL)

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:____

TELEPHONE NUMBER: A/C_____-_____-_____

DATE OF LAST GENERAL MEDICAL EXAMINATION:_____
(MONTH DAY YEAR)

HAS HE/SHE HAD ANY RECENT EXPOSURE TO ANY CONTAGIOUS DISEASE? ____ Yes ____ No Date _____

WHAT KIND OR TYPE OF DISEASE? Explain_____

_____

_____

HAS HE/SHE HAD ANY SERIOUS ILLNESS OR OPERATION IN THE PAST? __Yes __No

(IF YES PLEASE DESCRIBE) Date: _____ Explanation:_____

_____

DOES YOUR SON/DAUGHTER HAVE ANY TROUBLE WITH BONES OR JOINTS?
___Yes ___No Explain: _____

_____

_____

_____

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HAS YOU SON/DAUGHTER HAD ANY OF THE FOLLOWING ILLNESSES:
(CHECK ALL THAT APPLY)

__Asthma __Stomach Problems __Kidney Trouble __Diabetes-Insulin

__Heart Trouble __Rheumatic Fever __Convulsions-Epilepsy __Sinus Infections

__Nose Bleed __Fainting Spells __Bed Wetting __Sleep Walking __Cramps

FOR EACH ILLNESS CHECKED, PLEASE EXPLAIN TO WHAT DEGREE OR SEVERITY HE OR SHE IS AFFECTED._____

_____

IS YOU SON/DAUGHTER ALLERGIC TO: __PLANTS: KINDS_____
__FOODS: KINDS_____
__INSECT BITES: KINDS_____
__MEDICATIONS: KINDS_____

DATE OF LAST TETANUS INJECTION:_____

IS YOUR SON/DAUGHTER TAKING ANY MEDICATION THAT MUST BE TAKEN DAILY? __YES __NO (IF YES, PLEASE EXPLAIN FULLY, THE DOSAGE, TIMES TO BE GIVEN AND REASON FOR THE MEDICATION.) _____

_____

_____

_____

_____