



Osceola County Sheriff's Office
Explorer Post 816
Explorer Application

Full Name: _____ **Date of Birth:** _____

Social Security No.: _____ **Place of Birth:** _____

Sex: _____ **Race:** _____ **Hgt:** _____ **Wgt:** _____ **Hair Color:** _____ **Eye Color:** _____

Present Home Address: _____

City, State, Zip Code: _____

Phone/ #: _____ **Cell #:** _____ **Email:** _____

How long have you lived at present address: _____

Previous Address: _____

Have you ever used any type of drugs other than those prescribed by a physician? _____
(Even experimental, or on a dare, including marijuana.) _____

Have you ever consumed an alcoholic beverage? _____

Have you ever smoked or used tobacco in any form? _____

Name of school you are attending: _____ **Grade:** _____

List all clubs or organizations of which you have been an active member: _____

Have you ever been suspended or expelled from school? _____ **If so, why?** _____

Have you ever been arrested? _____ **If so, why?** _____

Do you have a driver's license? _____ **Drivers License #:** _____ **State:** _____

Have you ever received a traffic citation? _____ **If yes, when?** _____

Do you have any special talents? _____

Why do you want to be an explorer? _____

FOR OFFICIAL USE ONLY: QI CHECK DATE: _____ OUTCOME: _____ OPERATOR: _____

Please list all members of your immediate family:

| NAME | RELATIONSHIP | ADDRESS | OCCUPATION | D.O.B. |
|------|--------------|---------|------------|--------|
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| | | | | |
| | | | | |

Father's Work Phone #: _____ Mother's Work Phone #: _____

Has any member of your immediate family ever been arrested? _____ If, yes explain:

Are you currently employed? _____ Where? _____

How long have you worked there? _____ Telephone # at work: _____

REFERENCES: List the names of three persons who are not related to you, not former employers, but are persons you have known for a reasonable amount of time. The persons you list may be asked to appraise your character, ability, experience, personality, and other qualities:

| NAME | ADDRESS | OCCUPATION | PHONE # |
|------|---------|------------|---------|
| | | | |
| | | | |
| | | | |

I affirm that this application contains no misrepresentation or falsification, omission, or concealment of material fact and that information given by me is true and complete to the best of my knowledge and belief. I am aware that statements made by me are subject to investigation.

Signature of Applicant

Sworn to and subscribed before me this _____ day of _____, _____.

Notary Public

Print, Type or Stamp Commissioned Name

Personally known _____ or produced identification _____, type of ID _____

**Osceola County Sheriff's Office
Explorer Post 816
STATEMENT OF CONFIDENTIALITY**

Florida Statutes prohibits the unauthorized disclosure of information from particular police records, including, but not limited to, juvenile cases, cases involving sexual battery and child abuse, pending Internal Affairs investigations, FCIC and NCIC information.

I understand the unauthorized disclosure of this or other protected information could lead to my dismissal from the program and possible criminal penalties.

As an Explorer for the Osceola Sheriff's Office, I understand that I will be held accountable under law for the disclosure of any information related to police matters or confidential cases. I further understand that I will not release, share, either verbally or in writing, any information obtained as a result of my participation as an Explorer unless specifically authorized in advance by an Osceola Sheriff's Office supervisor.

Explorer Signature

Date

Parent/Guardian Signature

Date

PHOTOGRAPHIC PERMISSION

Explorer's Name (Last) _____ (First) _____ (M.I.) _____

The Osceola County Sheriff's Office utilizes photographs and videotaping of the post and its activities for training, competition, and for their promotional material.

_____ I hereby give my permission for my child to be photographed or videotaped while staying and participating in the activities of the Sheriff's Explorer Post #816. I also give my permission for those photographs or videotaping to be used without charge by the Osceola County Sheriff's Office in their promotional materials.

_____ I DO NOT give my permission for my child to be photographed or videotaped by the Osceola County Sheriff's Office for use in their promotional materials.

Applicant Signature if 18 years old

Date

Parent/Guardian if minor

Relationship

Date

**Osceola County Sheriff's Office
Explorer Post 816
Release of Civil Liability**

In consideration of the privileges being granted to _____ by the Osceola County Sheriff's Office, Explorer Post 816 and the Osceola County Sheriff's Office to use Osceola County Sheriff's Office facilities and benefit from participation in the Osceola County Sheriff's Explorer program, I hereby assume all risks of personal injury or death, and property damage or loss, from whatever causes arise while the above-named child is using, intending to use, or has used these privileges, including but not limited to: Firearms Training, Simunition Training, Defense Tactics, Repelling, Obstacle Course, as well as being transported to and from any off-site location and approaching, entering or using any facility of the Osceola County Sheriff's Office.

Further, I indemnify and hold harmless the Osceola County Sheriff's Office, its officers, employees, agents and servants, from and against all damages, suits and claims, including attorney's fees, that may result from the above-named child using these privileges.

I further understand and agree that these privileges may be revoked at anytime by the Osceola County Sheriff's Office.

Applicant Signature if 18 years old

Date

Parent or Guardian if minor

Date

NOTARY PUBLIC INFORMATION

Notary Signature

Date

Personally known _____ or produced identification _____, type of ID _____

Notary Public Stamp

**Osceola County Sheriff's Office
Explorer Post 816
AUTHORIZATION FOR MEDICAL TREATMENT**

I, _____ as parent/guardian of _____,

hereby request that the Osceola County Sheriff's Office notify, if possible, the person(s) listed on the Osceola County Sheriff's Office Explorer Medical Profile in the event of illness, injury or emergency. If the listed person(s) cannot be reached or if the above-referenced minor child requires immediate medical treatment, I hereby request and authorize representatives of the Osceola County Sheriff's Office to seek immediate medical treatment and to transport, or seek the transportation, by ambulance if necessary, of said minor to a medical facility for any treatment deemed to be medically necessary for the health, safety or welfare of the child. Further, I give each and every employee of the Osceola County Sheriff's Office my power of attorney to execute any documents relative to obtaining such aforesaid medical treatment in my absence.

I hereby agree to be financially responsible for any medical treatment and Emergency Medical Services transportation not covered by the Boy Scouts of America, Explorer Group Policy.

Applicant Signature if 18 years old

Date

Parent or Guardian if minor

Date

NOTARY PUBLIC INFORMATION

Notary Signature

Date

Personally known _____ or produced identification _____, type of ID _____

Notary Public Stamp

Osceola County Sheriff's Office
Explorer Post 816
MEDICAL PROFILE

| | | | |
|--------------------------|--------------------|----------------|--|
| NAME | | D.O.B. | |
| ADDRESS | | S.S. # | |
| CITY | | PHONE # | |
| STATE/ZIP | | PHONE # | |
| LEGAL GUARDIAN | | PHONE # | |
| EMERGENCY CONTACT | | CELL # | |
| ALLERGIES | MEDICATIONS | DOSAGE | |
| | | | |
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|------------------------|-------------------------------|
| MEDICAL HISTORY | IF YES, PLEASE EXPLAIN |
|------------------------|-------------------------------|

| | | | |
|---|---|---------------------------|--|
| Y | N | ASTHMA | |
| Y | N | BLEEDING DISORDERS | |
| Y | N | DIABETES | |
| Y | N | EPILEPSY/SEIZURE DISORDER | |
| Y | N | BROKEN BONES | |
| Y | N | HEADACHES | |
| Y | N | HEARING PROBLEMS | |
| Y | N | HEART CONDITIONS | |
| Y | N | HIGH BLOOD PRESSURE | |
| Y | N | THYROID DISORDER | |
| Y | N | VISION PROBLEMS | |
| Y | N | ANY OTHER CONDITIONS? | |

| | | |
|----------------------------------------|------------------------|---------------------------|
| TETANUS SHOT STATUS: (MARK ONE) | LESS THAN FIVE (5) YRS | GREATER THAN FIVE (5) YRS |
|----------------------------------------|------------------------|---------------------------|

| | | | |
|----------------------------------|--|----------------|--|
| PHYSICIANS NAME | | PHONE # | |
| MEDICAL INSURANCE NAME | | | |
| ADDRESS | | | |
| CITY, STATE, ZIP, PHONE # | | | |
| GROUP # / POLICY # | | | |

Applicant if 18 or Parent/Guardian if minor

Date

Notary Signature

Date

Personally known _____ ID _____,

NOTARY STAMP: