



# O'Fallon Public Safety

285 N. Seven Hills Rd.

O'Fallon IL 62269

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Due to the nature of the program, situations you will be involved in, and the information you will have access to; it is imperative that all applicants are thoroughly screened. Therefore all information must be filled out completely.

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## Public Safety Explorer Application

### Personal Information

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First MI Month Day Year

Address: \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ / \_\_\_\_\_ How long have you resided at the above address? \_\_\_\_\_  
Home Cellular

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Expiration: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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### Parent(s) / Legal Guardian(s) Information

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ / \_\_\_\_\_ EMERGENCY Number: \_\_\_\_\_  
Home Cellular

Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ / \_\_\_\_\_ EMERGENCY Number: \_\_\_\_\_

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## EMPLOYMENT HISTORY

### LIST MOST RECENT JOB

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Position: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Phone Number \_\_\_\_\_

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## REFERENCES

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ / \_\_\_\_\_  
Home Cellular

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ / \_\_\_\_\_  
Home Cellular

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Have you ever been arrested?     ☐ Yes     ☐ No

If yes, explain why and by whom:

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Explain your interest in O'Fallon Public Safety Explorer Post(s)

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I \_\_\_\_\_ hereby certify the facts contained in this application are true and correct to the best of my knowledge and understand, if accepted, falsified statements on this application shall be grounds for dismissal from the program.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Legal Guardian (*if under 18 years of age*)

\_\_\_\_\_  
Date

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***For Official Use Only***

Background check complete \_\_\_\_\_

Consent and Release form \_\_\_\_\_

Waiver/Photo Release \_\_\_\_\_

Medical Release \_\_\_\_\_



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## Consent, Waiver, and Release Form

I have voluntarily applied to join the O'Fallon Public Safety Explorer Program. As part of this application I agree and understand that the use of any and all equipment, tools, vehicles or participation in any department activities shall be at my own risk.

Based on my understanding and acceptance of the risks involved in participation in the Explorer program and in consideration of granting my application to participation in the activities of the program I waive and release any claims that I have as a result of my participation in any of the program activities. The O'Fallon Public Safety Division, the City of O'Fallon, or any of their officers, elected and appointed officials, officers, employees or agents shall not be liable to me or to anyone making claims on my behalf for injuries to my person or to my property (willful and wanton conduct of the above excluded) arising out of my participation in the Explorer program.

I further agree to release O'Fallon Public Safety, the City of O'Fallon, or any of their officers, elected and appointed officials, employees or agents from any liability resulting from any act or omission on their part with respect to all Explorer program activities (willful and wanton acts excluded).

**I understand that great care will be taken to protect Explorer Post members from harm.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## EXPLORERS ONLY

I understand as participant in the Explorer program I may encounter dangerous situations, including, but not limited to: TASER Exposure, Defensive Tactics Training, being in close proximity to arrested individuals and combative ambulatory patients, exposure to bloodborne pathogens, roadway traffic, hoses expressing high pressure water, operation of hydraulic tools, during emergency services training, as well as at the scene of emergency calls. These dangers may include physical injury as well as mental health impact through viewing traumatic events. I further understand that as a participant in the program I may be allowed to ride along with trained first responders in emergency vehicles and that participating in such and activity may be dangerous at times. I acknowledge that it is sometimes necessary for emergency vehicles to drive in violation of the normal rules of the road, as privileged by state law and that collisions sometimes occur that could result in serious injury or death. I also acknowledge that law enforcement often deals with persons who are combative and assaultive and that through my participation in this program I may be exposed to such persons and that such exposure could lead to serious injury or death.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

The undersigned parent(s)/guardian(s) of \_\_\_\_\_, have read and understand the above waiver and release. I/We give our consent to our son/daughter/dependent's participation in the O'Fallon Public Safety Explorer program. We promise to be bound by the terms of the above stated waiver and release for my/our child and for myself/ourselves.

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



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## Background Check Authorization

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### Notification

The position for which I am being considered requires me to consent to a criminal background check due to a legitimate safety interest. This check includes the following: Criminal history reference searches for felony and misdemeanor convictions at the county and federal levels of every jurisdiction where I currently reside or where I have resided during the past 7 years; and sex offender registry searches at the county and federal levels in every jurisdiction where I currently reside or where I have resided. *Note: If records are considered juvenile records, care will be taken to ensure that confidentiality protections are not infringed. All findings shall be kept separate from records considered public, shall remain confidential and not be publicly disclosed, except as otherwise allowed by law.*

### Authorization

I hereby authorize O'Fallon Public Safety to conduct the criminal background check described above. In connection with this, I also authorize the use of law enforcement agencies and/or private background check organizations to assist O'Fallon Public Safety in collecting this information, if needed.

I also am aware that records of arrests on pending charges and/or convictions are not an absolute bar to participation. Such information will be used to determine whether the results of the background check reasonably bear on my trustworthiness or my ability to perform the duties of my position in a manner which is safe for O'Fallon Public Safety employees, residents and visitors of O'Fallon Illinois.

Position(s) Applied for: \_\_\_\_\_

### **Please print (for identification purposes):**

Full Legal Name: \_\_\_\_\_  
First Middle Last

Other Names You Have Used in Past Seven Years: \_\_\_\_\_

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

Previous Address (most recent): \_\_\_\_\_

Addresses in the 7 years prior to completing this authorization: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Month/Day/Year

Gender: Female \_\_\_\_\_ Male \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Driver's License # \_\_\_\_\_

State of Driver's License \_\_\_\_\_

Have you ever been convicted of a criminal \*offense or have any pending criminal\* charges against you?

\*This refers only to felonies and misdemeanors; you do not need to include non-criminal traffic violations or municipal ordinance violations.

Yes \_\_\_\_\_ (provide detail on next page) No \_\_\_\_\_

*To the best of my knowledge, the information provided in this Notice and Authorization and any attachments thereto is true and complete. I understand that any falsification or omission of information may disqualify me for this position and/or may serve as grounds for the severance of my membership with the O'Fallon Public Safety Explorer Program. By signing below, I hereby provide my authorization to the O'Fallon Public Safety Explorer Program to conduct a criminal background check.*

\_\_\_\_\_  
Participant's signature

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

\_\_\_\_\_  
Parent/guardian signature

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



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## Medical Informed Consent, Release Agreement, and Authorization

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

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

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 City of O'Fallon, its employees, agents, volunteers, elected and appointed officials and any departments that this waiver would apply to, Learning for Life, the local council, activity coordinators, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation including but not limited to, personal injury (including but not limited to physical injury, emotional injury, or mental distress), property damage, wrongful death, medical expenses, and any and all claims for damages. The activities may include (but are not limited to): TASER Exposure, Defensive Tactics Training, being in close proximity to arrested individuals and combative ambulatory patients, exposure to bloodborne pathogens, roadway traffic, hoses expressing high pressure water, operation of hydraulic tools, that may occur during emergency services training, as well as at the scene of emergency calls.

The Participant (or parent if Participant is under 18 years of age) agrees and covenants to, prior to consenting to this Waiver and prior to participating in the Program that he or she: (a) has become familiar with the level of physical or mental stress and hazards involved with participation in the Program; and (b) has confirmed with a medical professional that the Participant is physically and mentally capable of participating in the Program.”).

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 or time is critical to the medical situation, 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.

\_\_\_\_\_  
Participant's signature

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

\_\_\_\_\_  
Parent/guardian signature for youth (*If participant is under the age of 18*)

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

## General Information/Health History

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

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

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

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

Telephone: \_\_\_\_\_ / \_\_\_\_\_  
Home Cellular

In case of emergency, notify the person below:

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

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

Home phone: \_\_\_\_\_ Cell 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/eyes/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 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	



O'Fallon Explorer Participant: \_\_\_\_\_

<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:

List any other medical conditions not covered above:

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## Allergies/Medications

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

Yes	No	Allergies / Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medications	
<input type="checkbox"/>	<input type="checkbox"/>	Food	
<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<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 (with name of participant affixed)

Medication	Dose	Frequency	Reason

Administration of the above medications is approved for youth by:

\_\_\_\_\_  
Parent/guardian name

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date



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## SOCIAL MEDIA / PHOTOGRAPH RELEASE

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Name of Explorer/Volunteer: \_\_\_\_\_

I give O'Fallon Public Safety, their assigns, licensees, and legal representatives, the irrevocable right to use my picture, portrait, or photograph (or that of my child if he or she is under 18), in all forms, media, and manners without restriction as to changes or alterations, for advertising, promotion, exhibition, or any other lawful purposes.

I waive the right to inspect or approve the photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use be known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the photographs.

I have read this release and waiver and am fully familiar with its contents.

\_\_\_\_\_  
Explorer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Explorer's Parent/Legal Guardian

\_\_\_\_\_  
Date