Community Ambulance Company
Youth Squad

The Goal of the Community Ambulance Youth Squad is to train and prepare youths for adult membership in the Community Ambulance Company when they reach 18 years of age.

The Community Ambulance Company, which relies on volunteer members, continually needs new members to provide emergency ambulance services to the communities of Bayport, Bohemia, Oakdale, Sayville and West Sayville.

This will be accomplished by allowing youths at the age of 14 years to join the Community Ambulance Company Youth Squad.

As a member of the Youth Squad, members will be trained in all aspects of pre-hospital emergency care. This includes patient assessment, CPR, bleeding control, fracture management, oxygen administration, and other trauma and medical emergencies. In addition, members are invited to attend all company trainings, drills and parades.

Meetings will be held on Thursdays from 7:00pm to 8:00pm.

Attendance is crucial to maintain continuity in training.

When Youth Members reach the age of 16 years, they will be considered for participation in actual emergency ambulance operations after at least 6 months of Youth Squad participation. This will consist of reporting for a weekly duty shift (3 to 6hrs) and responding to actual ambulance assignments while on the ambulance as an observer. This will only be allowed only after the member has completed the necessary training that is required and the parents/guardians attend an orientation of the program and approve.

Community Ambulance Youth Squad Contact Information:

Email: youthsqd@communityamb.org
Email is preferred for a speedy response.

Phone: 631-567-2586
(Leave a Message)

Community Ambulance Company
P.O. Box 450, Sayville, NY 11782 631-567-2586
Youth Squad Membership Application

PERSONAL DATA: **Date of Application: _____**

Name: _____ **DOB: _____**
Address: _____ **Phone#: _____**
City: _____ State: _____ Zip: _____ **Cell #: _____**

Email Address: _____ **Cell Provider:_____ (Texting)**

How do you want to receive Youth Squad Notifications: (Circle all that apply) Text Email
(Notifications will be sent to both the Youth Squad Member and Parent.)

EMERGENCY CONTACT INFORMATION:

Parents/Guardians: _____ **Address: _____**
Phone (H):_____ Phone (W):_____ Phone (Cell):_____
Email: _____ **Cell Provider: _____(Texting)**
Alternate Emergency Contact: _____ **Relationship: _____**
Phone (H):_____ Phone (W):_____ Phone (Cell):_____

EDUCATION:

School: _____ Grade: _____
First Aid or CPR Training: _____Expiration Date: _____ (Attach Copies)

EMPLOYMENT/EXTRA CURRICULAR ACTIVITIES:

Dates From/To: _____ Name of Employer/Organization: _____

Explain briefly why you wish to be a member of Community Ambulance Youth Squad:

_____

_____

I hereby certify that the answers to all of the preceding questions are true, complete, and accurate. I clearly understand that any false statement on this application may terminate any further consideration for membership. I also understand that, if accepted my continued membership will be contingent on abiding by the rules, regulations, policies, and procedures set forth by Community Ambulance Company. I hereby give permission to the Community Ambulance Company to investigate any or all of the statements on this application. I hereby give permission for my child to leave the Community Ambulance Company property at the conclusion of meetings or trainings without an adult present. In case of accident, illness or suspected injury, I hereby authorize a member of Community Ambulance staff to transport my child to the nearest available emergency room and/or authorize treatment for my child.

Applicant's Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Community Ambulance Company
Youth Squad

Confidential Medical Record

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City:_____ Zip: _____

Phone # (H): _____ Phone #: (W)_____

Emergency Contact: _____Relationship: _____

Phone #: _____

Alternate Emergency Contact: _____ Relationship: _____

Phone #: _____

Physician: _____ Phone #: _____

Address: _____ City: _____ Zip:_____

Allergies: _____

Medications:

_____

_____

Special Needs/Dietary Restrictions:

_____

_____

Medical History:

_____

_____

_____

_____ _____ _____

Parent/Guardian Name (Print) Signature Date

_____ _____ _____

Youth Squad Member Name Signature Date