



Marine Military Academy

ADMISSIONS OFFICE

320 Iwo Jima Boulevard

Harlingen, TX 78550

TEL: (956) 423-6006 FAX: (956) 421-9273

REPORT OF MEDICAL HISTORY

(Submit to Physician or Medical Provider)

Name of Cadet (Applicant): _____

(please print)
(mm/dd/yyyy)

Last

First

Middle

Date of Birth

MANDATORY STATE REQUIREMENT

IMMUNIZATIONS:

PLEASE COMPLETE ALL BLANKS ATTACHMENTS NOT ACCEPTED

DPT/DT						
Polio						
MMR						
Hep B						
Hep A						
Varicella Vaccine						
Hx Chicken Pox						
Meningococcal			Other			

*Visual Acuity: OD _____ OS _____ OU _____ *Hearing: AD _____ AS _____ WNL _____ AU _____

Report of Physical: Height (inches): _____ Weight (lbs): _____ Blood Pressure: _____

Please answer all of the following questions: (comment on all positive answers; use a separate sheet if needed)

	YES	NO		YES	NO		YES	NO
Chicken Pox; If yes, state age:	0	0	Chronic Cough	0	0	Anxiety/Nervousness	0	0
Measles	0	0	Sinusitis/Hay fever	0	0	Panic disorder	0	0
German Measles	0	0	Asthma	0	0	Bipolar I, II, nos	0	0
Mumps	0	0	Tuberculosis	0	0	Depression/Dysthymia	0	0
ENT Problems	0	0	Kidney Disease	0	0	ODD	0	0
Pulmonary Problems	0	0	Cardiac Disease	0	0	OCD	0	0
Neurological Problems	0	0	Orthopedic Problems	0	0	PTSD	0	0
Congenital Abnormalities	0	0	Surgery/Operations	0	0	Tourettes Syndrome	0	0
Alcohol or Drug Use	0	0	Head Injury	0	0	ADD/ADHD	0	0
Nocturnal Enuresis	0	0	Seizures/Epilepsy	0	0	Insomnia	0	0
Schizophrenia	0	0	Conduct disorder	0	0	Asperger Syndrome	0	0
Paranoia/Psychosis	0	0	IED	0	0	Autism	0	0

Other Unlisted Problems/Conditions: (Explain: attach office notes or use separate sheet)

Are the following systems normal? (Please fully describe any abnormalities.)

	NORMAL	ABNORM		YES	NO
1. Head/Ears/Eyes/Nose/Throat	0	0	ALLERGIES:		
2. Respiratory System	0	0	10. Penicillin	0	0
3. Cardiovascular System	0	0	11. Sulfa Drugs	0	0
4. Gastrointestinal	0	0	12. Serum	0	0
5. Genitourinary/Hernia	0	0	13. Foods (state which) _____	0	0
6. Musculoskeletal	0	0	14. Other: _____		
7. Metabolic/Endocrine	0	0			
8. Neuropsychiatric	0	0			
9. Dermatological/skin disorder	0	0			

Is there impaired function of any organ? (Please list) _____ YES 0 NO 0

Does the applicant have any physical limitations? (Please list) _____ YES 0 NO 0

Is the applicant undergoing or has undergone psychiatric treatment? (Please list) _____ YES 0 NO 0

Is the applicant undergoing or has undergone medical treatment? (Please list) _____ YES 0 NO 0

Is the applicant taking medication? (Please list) _____ YES 0 NO 0

Physician's Signature: _____ Date: _____

Physician Name: _____ Phone: _____ Fax: _____

(please print or stamp)

Address: _____

11/13/2013



Marine Military Academy

MEDICAL ADDENDUM

(Parent/Guardian must complete)

Name of Cadet (or Applicant): _____

Please Print

Last

First

Middle

- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| 1. During the past 12 months (since his last doctor physical) has your son: | | |
| a. been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. had an injury requiring a doctor's visit? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. had an illness lasting more than one week? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above questions, please provide date(s) and reason(s): _____

- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your son take any medication(s) regularly? | | |

If yes, please list medication with corresponding diagnosis: _____

- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is there a reason limits should be put on your son's participation in sports? | | |

If yes, please explain reason(s): _____

- | | | |
|---|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you prohibit your son from participation in contact sports such as football and/or boxing? | | |

If yes, please explain reason(s): _____

- | | | |
|---|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has your son had a concussion, fracture or been knocked out? | | |

If yes, please explain reason(s) and date(s) of injury: _____

- | | | |
|---|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has your son had convulsions, seizures, or been diagnosed with Epilepsy? | | |

If yes, please explain reason(s) and date(s) of occurrence: _____

- | | | |
|---|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is your son currently undergoing or has he undergone psychiatric care? | | |

If yes, please explain reason **and include** a letter along with three office notes from the psychiatrist/doctor: _____

- | | | |
|------------------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is your son missing any organs? | | |

If yes, please explain: _____

- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is your son wearing a dental appliance? (i.e braces, retainer, etc..) | | |

- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has your son been treated for a back or neck injury? | | |

If yes, please explain reason(s) and date(s) injury: _____

- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is your son allergic to any medication(s)? | | |

If yes, please list medication(s) with allergic reaction symptom(s): _____

- | | | |
|---|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does your son have any condition or undergoing medical treatment not otherwise indicated? | | |

If yes, please explain: _____

13. My son received a TB skin test on _____ (date) result was negative on _____ (date).

The primary purpose of a TB screening is to maintain a healthy and safe campus environment and to reduce the direct and indirect costs associated with a case of tuberculosis disease on campus.

14. Parent/Guardian permission required for son to receive the influenza vaccine at a cost of \$25.00 billable to the parent/guardian. YES NO Not Applicable: vaccine given: _____ (date).

The Influenza vaccine will be given between October and November each year. It is NOT a required vaccine.

- | | | |
|---|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. (Enrolled Cadet) Has your son received immunizations not otherwise indicated or recorded by the MMA Medical Dept? Please provide an updated copy if your answer is yes. | | |

This form is also required annually (for an enrolled Cadet) and must be received by the MMA Medical Department prior to participation in any sport, intramural activity, practice, or game either on or off-season. The questions are designed to supplement the MMA Report of Medical History (doctor physical) that is required for initial enrollment. If changes occurred in your Cadet's health making it hazardous for him to participate, please note the changes. All "YES" responses not previously addressed on the Report of Medical History form require an updated doctor physical. All changes to your Cadet's health must be reported to the Medical Department to ensure no further injury occurs and that treatment is either started or completed as prescribed. I certify all information contained above is true, complete and correct.

Date: _____ Parent/Guardian Signature Authorization: _____



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CONSENT & INSURANCE FORM

Name of Cadet (Applicant): _____
Please Print Last First Middle

Date of Birth: _____ SSN: _____

Address: _____

Phone(s): _____
Home Parent/Guardian(s) Business

Name of Father/Guardian: _____ SSN: _____ DOB: __/__/__

Employer: _____

Name of Father's Insurance Company: _____

Address: _____ Insurance Phone: _____

Policy Number(s): _____ Deductible Amount: _____

Certificate Number(s): _____ Type of Policy: () Group () Individual

Name of Mother/Guardian: _____ SSN: _____ DOB: __/__/__

Employer: _____

Name of Mother's Insurance Company: _____

Address: _____ Insurance Phone: _____

Policy Number(s): _____ Deductible Amount: _____

Certificate Number(s): _____ Type of Policy: () Group () Individual

Is your Cadet covered under any of the above named policies? YES NO

If "yes" please indicate which plan(s): _____

Is your Cadet covered under any other health insurance policy? YES NO

If "yes" please provide insurance company's name and address: _____

_____ Policy Number(s): _____

Provide a copy of the front and back of each insurance card(s).

Important Note: Upon notification from MMA Medical Department that your son requires services from a specific medical provider, it is your responsibility to contact that provider to make financial arrangements for payment. Should medical services be required and you currently do not have an insurance provider, you must contact the *pharmacy with your credit card number. The same applies to any medical provider your son may require assistance from.

This authorization applies to the Cadet/Camper (Applicant) named above:

I, as () parent, () guardian, () managing conservator, have authorized to consent to medical treatment of the foregoing minor. I hereby consent to routine medical treatment (including, but not limited to, minor illness or injury) by contracted physicians of the Marine Military Academy or other physicians and/or other medical professionals selected by the Academy and duly authorized officials of the Academy. I also hereby give Marine Military Academy and its authorized officials' authority to consent to emergency medical, surgical, or dental treatment, understanding that attempts to contact me have failed. Should injury occur to my son/ward during his attendance at the Marine Military Academy, I hereby authorize any and all hospitals, physicians or other medical providers to furnish a detailed statement of charges to the Marine Military Academy in order that they may process any applicable student accident insurance claims. The Marine Military Academy, to whom I give this authority, is related to said minor as an educational institution in which he is enrolled as a student/camper and not financially responsible.

I certify that the insurance information shown here, to the best of my knowledge, is true, complete, and correct. A photocopy of this authorization shall be as valid as the original.

Signature of Parent/Guardian/Managing Conservator

Date

**See reverse side of this form*

10/16/2014



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MEDICAL PROVIDERS AND PHARMACY

In the event your Cadet/Camper needs to be examined or treated medically, Marine Military Academy (MMA) will provide transportation to and from the office of the physician or dentist. Prescribed medicine may be mailed to the MMA Medical Department or may be procured from the local pharmacy listed below. (No paper prescriptions)

Except for emergency care or other circumstances where time does not permit, it is your responsibility to contact the medical provider or pharmacy, in advance, to make financial arrangements for payment. MMA does not act as an intermediary for payment. Medical expenses and prescription charges cannot be charged to your MMA account. If you anticipate recurring prescription medicine charges, please provide credit card charging authority to the pharmacy listed below.

MMA has a prescription delivery/pick up relationship with the following pharmacy:

PHARMACY

Muniz Rio Grande Pharmacy (956) 423-1753

- Please contact the MMA Medical Department (956) 423-6006 ext 854 to make other pharmacy arrangements.



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e-mail: admissions@mma-tx.org web page: www.mma-tx.org

CONFIDENTIAL SCHOOL REPORT

(Submit to School of *Current* Enrollment)

NAME OF APPLICANT: _____ CURRENT GRADE LEVEL: _____

To the Principal or Counselor:

The above named student has applied for admission to the Marine Military Academy. MMA has a very demanding academic program as well as a rigorous physical program. Please ask the Principal, Vice Principal or Counselor who knows him best to complete this form and return it to the Marine Military Academy or the student's parent/guardian. This form will be used in the admission process only and will not become a part of the student's permanent record.

Academic Evaluation: (Please check the appropriate rating)

	Limited	Fair	Average	Good	Outstanding
Academic Potential					
Academic Achievement					
Ability to Write					
Ability to Express Ideas Orally					
Attention Span					
Maturity in Terms of Age/Grade					
Social Adjustments with Peers					
Leadership Potential					
Classroom Conduct					
Self-confidence					
Fulfills Responsibilities					
Cooperation with Adults					
Cooperation with Parents					
Parent Cooperation with School					

- Is your school accredited? Yes No
- Is the applicant eligible to re-enter your school next term? Yes No
- Is the applicant currently in a Special Education Program? Yes No
If yes, please state why, list modifications, and attach IEP or ARD, 504, BIP
- Has the applicant been involved in acts of dishonesty? Yes No
- Has the applicant been involved in substance abuse? Yes No
- Has the applicant participated in or stimulated disorderly, disruptive or unmannerly conduct? Yes No
- Has the applicant exhibited unsatisfactory adjustments to other students? Yes No
- Has the applicant had physical health problems? Yes No
- Has the applicant had emotional health problems? Yes No
- Has the applicant been disciplined by administrative officers or student judiciary? Yes No
- Has the applicant been suspended? Yes No
- Has the applicant been expelled? Yes No
- Has this student exhibited any behavior that would indicate a (probability) (possibility) (danger) that he (will) (could) (might) abuse or assault a fellow student?..... Yes No
- Has this student made any statements or threats that would indicate a risk of harm toward others?..... Yes No

For questions 4-14 please explain all "yes" answers thoroughly (continue on back if needed or a separate sheet of paper)

School: _____ Phone: _____

Address: _____ Fax: _____

Date: _____ Signature: _____ Title: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Dear Principal or Counselor:

Please give us your candid opinion of this applicant as a student and citizen. We wish to know about his work habits, motivation, sense of honor, responsibility, sense of humor, areas of strength and areas of weakness. We are particularly interested in your estimate of his potential. If there are any reasons why you would NOT recommend this applicant as a student, please share those thoughts with us as well. Thank you.



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ENGLISH TEACHER'S CONFIDENTIAL EVALUATION

NAME OF APPLICANT: _____ CURRENT GRADE LEVEL: _____

Academic Evaluation: (Please check the appropriate rating)

	Limited	Fair	Average	Good	Outstanding
Academic Potential					
Academic Achievement					
Ability to Write					
Ability to Express Ideas Orally					
Attention Span					
Maturity in Terms of Age/Grade					
Social Adjustments with Peers					
Leadership Potential					
Classroom Conduct					
Self-confidence					
Fulfills Responsibilities					
Cooperation with Adults					
Cooperation with Parents					
Parent Cooperation with School					

Please give us your candid opinion of this applicant as a student and citizen. We wish to know about his work habits, motivation, sense of honor, responsibility, sense of humor, areas of strength and areas of weakness. We are particularly interested in your estimate of his potential. If there are any reasons why you would NOT recommend this applicant as a student, please share those thoughts with us as well. Thank you. (For more space, please use the back of this sheet.)

Name of Teacher: _____ Subject Taught: _____

School: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Date: _____



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MATH TEACHER'S CONFIDENTIAL EVALUATION

NAME OF APPLICANT: _____ CURRENT GRADE LEVEL: _____

Academic Evaluation: (Please check the appropriate rating)

	Limited	Fair	Average	Good	Outstanding
Academic Potential					
Academic Achievement					
Ability to Express Ideas Orally					
Attention Span					
Maturity in Terms of Age/Grade					
Social Adjustments with Peers					
Leadership Potential					
Classroom Conduct					
Self-confidence					
Fulfills Responsibilities					
Cooperation with Adults					
Cooperation with Parents					
Parent Cooperation with School					

Please give us your candid opinion of this applicant as a student and citizen. We wish to know about his work habits, motivation, sense of honor, responsibility, sense of humor, areas of strength and areas of weakness. We are particularly interested in your estimate of his potential. If there are any reasons why you would NOT recommend this applicant as a student, please share those thoughts with us as well. Thank you. (For more space, please use the back of this sheet.)

Name of Teacher: _____ Subject Taught: _____

School: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Date: _____



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TRANSCRIPT REQUEST FORM

(Submit to School of *Current* Enrollment)

NAME OF STUDENT (Applicant): _____

Date: _____

To (School of Current Enrollment): _____

From (Parent/Guardian): _____

I authorize the Marine Military Academy to receive full records for my son/ward. Please forward official transcripts and complete records reflecting subjects, grades, credits, standardized testing, special education records and disciplinary records to the Marine Military Academy at the address above.

To determine correct grade level placement and proper scheduling, I authorize the Marine Military Academy to have the following information:

- ◆ Complete transcript of record including current grading scale and explanation of grading codes.
- ◆ Applicant's most recent report card for semester work in progress. Upon completion of semester work in progress please forward final transcripts to the Marine Military Academy Admissions Office.
- ◆ Results of standardized tests (include test names and dates administered as well as any special education records, tests, evaluations, ARD's or IEP's, to include most recent IQ testing result and most recent psychological evaluation)
- ◆ Applicant's current grade level: _____
- ◆ Number of credit hours completed to date: _____ Number attempted: _____
- ◆ Current GPA: _____

Thank you for your assistance.

X _____
Signature of Parent/Guardian

11/14/2013