



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



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MEDICAL ADDENDUM

(Parent/Guardian must complete)

Name of Cadet (or Applicant): _____

Please Print Last First Middle

1. During the past 12 months (since his last doctor physical) has your son:
- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| 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): _____

2. Does your son take any medication(s) regularly? YES NO
If yes, please list medication with corresponding diagnosis: _____

3. Is there a reason limits should be put on your son's participation in sports? YES NO
If yes, please explain reason(s): _____

4. Do you **prohibit** your son from participation in contact sports such as football and/or boxing? YES NO
If yes, please explain reason(s): _____

5. Has your son had a concussion, fracture or been knocked out? YES NO
If yes, please explain reason(s) and date(s) of injury: _____

6. Has your son had convulsions, seizures, or been diagnosed with Epilepsy? YES NO
If yes, please explain reason(s) and date(s) of occurrence: _____

7. Is your son currently undergoing or has he undergone psychiatric care? YES NO
If yes, please explain reason **and include** a letter along with three office notes from the psychiatrist/doctor: _____

8. Is your son missing any organs? YES NO
If yes, please explain: _____

9. Is your son wearing a dental appliance? (i.e braces, retainer, etc..) YES NO

10. Has your son been treated for a back or neck injury? YES NO
If yes, please explain reason(s) and date(s) injury: _____

11. Is your son allergic to any medication(s)? YES NO
If yes, please list medication(s) with allergic reaction symptom(s): _____

12. Does your son have any condition or undergoing medical treatment not otherwise indicated? YES NO
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.

15. (Enrolled Cadet) Has your son received immunizations not otherwise indicated or recorded by the MMA Medical Dept? YES NO
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:

RGV Hometown Pharmacy

608 E. Harrison Avenue
Harlingen, TX 78550

Phone: (956) 496-2093
FAX: (956) 496-2098

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