Marine Military Academy

ADMISSIONS OFFICE
320 Iwo Jima Boulevard / Harlingen, Texas 78550
TEL: (956) 423-6006 ext 861 FAX: (956) 421-9273
E-mail: admissions@mma-tx.org

Attach Current Photo Here

APPLICATION FOR ADMISSION

Submission must include a check for the application fee (non-refundable) and a copy of the Applicant's birth certificate

THIS APPLICATION IS FOR GRADE LEVEL: ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ PG ☐ N/A **YEAR**_____

☐ Fall Entry ☐ Mid-Term Entry ☐ Summer Camp ☐ Summer Camp with Aerospace ☐ English as a Second Language (ESL)

Please print or type

Last Name_____ First Name: _____

Middle Name: _____ Name Usually Called: _____

APPLICANT'S CONTACT INFORMATION (student lives w/): ☐ Father ☐ Mother ☐ Other (indicate by marking below)

Address: _____

City _____ State_____ Zip_____

HM #: ( )_____ Cell #: ( )_____ Email HM: _____

Date of Birth:_____ Place of Birth:_____ Nation of Citizenship:_____

Height: _____ Weight: _____ Shoe Size: _____ Social Security #: _____

Your response to the following racial/ethnic question is voluntary, but federal civil rights legislation and implementing regulations require this institution to submit counts of the student body by these racial/ethnic categories. Your cooperation, therefore, while voluntary, is essential to the accurate reporting of this information. How would you describe yourself? Please check one.

☐ White, Anglo, Caucasian (non-Hispanic)
☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander (including Indian subcontinent)
o Religion: _____
☐ Hispanic (including Puerto Rican & Latin American)
☐ Black, African-American, (non-Hispanic)
☐ Other (Specify)_____

Biological/Adoptive Father's Complete Name (L,F,M) _____ ☐ Living ☐ Deceased

Biological/Adoptive Mother's Complete Name (L,F,M) _____ ☐ Living ☐ Deceased

Biological/Adoptive Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married/Single

RESPONSIBLE PARTY:

FATHER (L,F,M):_____ ☐ Payor

Home Address: _____ City _____ State_____ Zip____ _____

HM #: ( )_____ Cell #: ( )_____ Email HM: _____

WK #:( )_____ FAX #:( )_____ Email WK:_____

Occupation: _____ Employer: _____

Spouse (step parent/other) (L,F,M):_____

WK #:( )_____ Cell #:( )_____ Email WK:_____

Occupation: _____ Employer: _____

MOTHER (L,F,M):_____ ☐ Payor

Home Address: _____ City _____ State_____ Zip____ _____

HM #: ( )_____ Cell #: ( )_____ Email HM: _____

WK #:( )_____ FAX #:( )_____ Email WK:_____

Occupation: _____ Employer: _____

Spouse (step parent/other) (L,F,M):_____

WK #:( )_____ Cell #:( )_____ Email WK:_____

Occupation: _____ Employer: _____

If Biological Parents are Divorced/Separated: Complete 1-3 below (please provide a copy of the custodial decree for our files):

1. **Name of Custodial Parent** (L,F,M):_____ ☐ Payor ☐ Joint Custody
2. **Name of Custodial Parent** (L,F,M):_____ ☐ Payor
3. **Name of Non-Custodial Parent** (L,F,M):_____ ☐ Payor

Indicate (above) to whom tuition and charges should be mailed by selecting "payor" box. If other please indicate below:

Name: (L,F,M):_____ Relationship to applicant?_____

Home Address: _____ City _____ State_____ Zip____ _____

HM #: ( )_____ Cell #: ( )_____ Email HM: _____

WK #:( )_____ FAX #:( )_____ Email WK:_____

Where did you first hear about the Marine Military Academy? (Please specify)

☐ Alumni name _____ ☐ Magazine _____ ☐ Current Cadet/Family _____
☐ Newspaper _____ ☐ Counselor _____ ☐ Word of Mouth _____
☐ Internet/Search Engine _____ ☐ Boarding School Directory _____ ☐ Other _____

Name and location of each school Applicant has attended during the past three years:

20 ___ Grade _____ School _____ Reason for leaving _____

20 ___ Grade _____ School _____ Reason for leaving _____

20___ Grade _____ School _____ Reason for leaving _____

20 ___ Grade _____ School _____ Reason for leaving _____

Please make selections for a foreign language in order of preference (1-2): ___ Spanish ___ Chinese

Does the applicant have any special gifts, interests or talents? (artistic, musical, athletic, etc.) ☐ Yes ☐ No

If so, please explain: _____

Has the Applicant been professionally diagnosed as requiring special education? ☐ Yes ☐ No

If so, please list the diagnosis given _____

Does the Applicant have a current I.E.P (Individualized Education Plan) or a B.I.P. (Behavioral Individualized Plan)? ☐ Yes ☐ No

If so, please explain and attach (applicant for academic enrollment only) the I.E.P or B.I.P. documentation filed by the school: _____

Has the Applicant ever been clinically diagnosed with the following psychiatric disorders? (Schizophrenia, Bipolar (I, II, NOS), Major depression, Dysthymia, Anxiety, Conduct disorder, (ODD) Oppositional-Defiant Disorder, (OCD) Obsessive-Compulsive Disorder, Tourettes Syndrome, Asperger Syndrome, ADHD, ADD, History of cutting or self-mutilation) ☐ Yes ☐ No

If so, please **circle each** and **list all** medication(s) prescribed by the treating primary care physician or psychiatrist: _____

_____

Has the Applicant ever been treated for or tested positive for substance abuse? Date of occurrence: _____ ☐ Yes ☐ No

If so, please have a urine drug screen performed by a physician or an independent laboratory and enclose the result.

Has the Applicant ever been involved with the juvenile authorities or been adjudicated a delinquent or dependent? ☐ Yes ☐ No

☐ On Probation ☐ Deferred Adjudication ☐ Awaiting Trial ☐ Convicted of a felony or misdemeanor ☐ Community Service

NOTE: Documentation relating to any of the above responsibility must be provided with this application.

I hereby certify that the information on this application is true and complete and that there are no disciplinary actions, criminal charges or juvenile proceedings pending that I have not disclosed. I understand that any material falsification or omission may be cause for dismissal.

Date: _____ Parent/Guardian Signature: _____

QUESTIONS (if more space is needed please attach your responses):

Describe your son's distinguishing characteristics (postive and/or contrary):

What are you hoping a Marine Military Academy experience can do for your son?

What are your son's ambitions, goals, future outlook?

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REPORT OF MEDICAL HISTORY

(Submit to Physician or Medical Provider)

Name of Cadet (Applicant):_____
(please print) Last First Middle Date of Birth (mm/dd/yyyy)

MANDATORY STATE REQUIREMENT

IMMUNIZATIONS: **PLEASE COMPLETE ALL BLANKS ATTACHMENTS 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
1.	Head/Ears/Eyes/Nose/Throat	0	0
2.	Respiratory System	0	0
3.	Cardiovascular System	0	0
4.	Gastrointestinal	0	0
5.	Genitourinary/Hernia	0	0
6.	Musculoskeletal	0	0
7.	Metabolic/Endrocrine	0	0
8.	Neuropsychiatric	0	0
9.	Dermatological/skin disorder	0	0

ALLERGIES:

		YES	NO
10.	Penicillin	0	0
11.	Sulfa Drugs	0	0
12.	Serum	0	0
13.	Foods (state which) _____	0	0
14.	Other: _____		

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:_____

9/9/2015

IMMUNIZATION REQUIREMENTS FOR ALL
TEXAS PUBLIC AND PRIVATE SCHOOLS

IN CCORDANCE WITH TEXAS STATE LAW THE MARINE MILITARY ACADEMY REQUIRES THAT EACH STUDENT BE FULLY IMMUNIZED. PROOF OF IMMUNIZATION OR MEDICAL EXEMPTION OR AN EXEMPTION FOR REASON OF CONSCIENCE MUST BE ON FILE FOR EACH STUDENT PRIOR TO ADMISSION.

REQUIRED IMMUNIZATIONS ARE LISTED BELOW:

DPT – TDAP **five** doses, the last one within the last 10 years (Required)

OPV – IPV **four** doses, the last one being on, or after the 4th birthday (Required)

MMR – **two** doses, the first one received after the 1st birthday (Required)

HEPATITIS B – **three** doses for students born after September 2, 1988 (Required)

HEPATITIS A - **two** doses for students born after September 2, 1992 (Required)

VARICELLA – **two** doses for anyone who has not had Chickenpox (Required)

MENINGOCOCCAL – **one** dose (Required) a booster 3-5yrs later

IMMUNIZATIONS MUST BE CURRENT BEFORE STUDENTS ARE ALLOWED TO ATTEND CLASSES (Title 25 Health Services, ss97.61-97.72 of the Texas Administrative Code)

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?	☐	☐
b. had an injury requiring a doctor's visit?	☐	☐
c. had an illness lasting more than one week?	☐	☐

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

2. Does your son take any medication(s) regularly? ☐ ☐
*If yes, please list medication with corresponding diagnosis:*_____

3. Is there a reason limits should be put on your son's participation in sports? ☐ ☐
*If yes, please explain reason(s):*_____

4. Do you <u>prohibit</u> your son from participation in contact sports such as football and/or boxing? ☐ ☐
*If yes, please explain reason(s):*_____

5. Has your son had a concussion, fracture or been knocked out? ☐ ☐
*If yes, please explain reason(s) and date(s) of injury:*_____

6. Has your son had convulsions, seizures, or been diagnosed with Epilepsy? ☐ ☐
If yes, please explain reason(s) and date(s) of occurrence: _____

7. Is your son currently undergoing or has he undergone psychiatric care? ☐ ☐
*If yes, please explain reason **<u>and include</u>** a letter along with three office notes from the psychiatrist/doctor:* _____

8. Is your son missing any organs? ☐ ☐
*If yes, please explain:*_____

9. Is your son wearing a dental appliance? (i.e braces, retainer, etc..) ☐ ☐

10. Has your son been treated for a back or neck injury? ☐ ☐
If yes, please explain reason(s) and date(s) injury: _____

11. Is your son allergic to any medication(s)? ☐ ☐
*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? ☐ ☐
*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? *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).

<u>Important Note</u>: 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 <u>not</u> 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.