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) Last First Middle Date of Birth
(mm/dd/yyyy)

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
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:____

11/13/2013

Marine Military Academy admits students of any race, color, and national or ethnic origin.

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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 θ NO θ

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

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

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*

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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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