U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	**CADET APPLICATION** **REPORT OF MEDICAL HISTORY**	FOR OFFICIAL USE ONLY

NOTICE

THIS DOCUMENT IS AN AUTHORIZATION, CONSENT AND RELEASE FORM. Upon enrollment, the information requested below is required to provide a medical provider an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the NSCC/NLCC training program. Also this information will be provided to a medical provider in case of injury or illness while participating in NSCC/NLCC activities. **If taking medications at time of enrollment, list in Block 9.**

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. You are encouraged to consult your private medical provider regarding past illnesses. Proof of immunization for polio, measles, mumps, rubella, hepatitis B, pertussis and tetanus plus diphtheria and Menactra vaccine for Meningitis must be attached.

After enrollment, use this form to screen cadets for continued medical fitness before sending to Orientation, Recruit, Advanced and/or other trainings.

Commanding Officers (CO) and Commanding Officers of Training Contingents (COTC) retain the obligation to deny acceptance for enrollment or training to any cadet if upon review of this form, it is determined that the cadet is not physically/medically qualified for participation unless Medical Condition and/or disability accommodation per ADA guidelines has been requested and approved.

1. UNIT INFORMATION

1a. Unit Name	**1b.** Region

2. PERSONAL INFORMATION

2a. Last Name	**2b.** First Name	**2c.** MI	**2d.** USNSCC ID Number

2e. Age	**2f.** Date of Birth (DD MMM YY)	**2g.** Sex ☐ Male ☐ Female	**2h.** Parent/Guardian Name

2i. Home Address	**2j.** City	**2k.** State	**2l.** Zip Code + 4

2m. Primary Phone	**2n.** Alternate Phone	**2o.** Date of Last Physical Examination (DD MMM YY)

3. MEDICAL PROVIDER/INSURANCE INFORMATION

3a. Medical Insurance Provider Name	**3b.** Medical Insurance Policy Number
3c. Medical Insurance Provider Address	**3d.** Medical Insurance Provider Phone
3e. Medical Provider Name	**3f.** Medical Provider Phone Number

4. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 9: explain treatment to return cadet to medically fit for NSCC)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	**YES**	**NO**		**YES**	**NO**
4a. Tuberculosis or live with someone with tuberculosis	☐	☐	**4n.** Head injury or concussion	☐	☐
4b. Chronic or recurrent abdominal or stomach pain	☐	☐	**4o.** Seizures, convulsions, epilepsy, or fits	☐	☐
4c. Asthma or breathing problems related to exercise, pollen, etc.	☐	☐	**4p.** Car, train, sea, and/or air sickness	☐	☐
4d. Been prescribed or use an inhaler	☐	☐	**4q.** A period of unconsciousness	☐	☐
4e. Loss of vision in either eye	☐	☐	**4r.** Heart trouble or murmur	☐	☐
4f. Loss of hearing or wear a hearing aid	☐	☐	**4s.** Received counseling for emotional or behavior disorder	☐	☐
4g. Impaired use of arms, legs, hands, feet	☐	☐	**4t.** Eating disorder (bulimia, anorexia)	☐	☐
4h. Knee problems	☐	☐	**4u.** Sleepwalking	☐	☐
4i. Broken bones(s) (cracked or fractured)	☐	☐	**4v.** Bedwetting	☐	☐
4j. Diabetes	☐	☐	**4w.** Been hospitalized *(if yes, why, when, where)*	☐	☐
4k. Anemia (including sickle cell)	☐	☐	**4x.** Any illness or injury not mentioned above *(if yes, explain)*	☐	☐
4l. Dizziness or fainting spells (including after exercise)	☐	☐	**4y.** Advised to avoid certain physical activities *(if yes, explain)*	☐	☐
4m. Frequent or severe headaches	☐	☐	**4z. FEMALES ONLY:** At what age did you begin menstrual cycle:		

REPORT OF MEDICAL HISTORY

5. IMMUNIZATION RECORDS (attach copy of immunization record to this form)

5a. Date of last tetanus or booster	**5b.** Date of Menactra Vaccine for Meningitis	**5c.** Date of negative PPD or Medical Provider Clearance for TB

6. ALLERGIES (Mark each item "YES" or "NO". Every item marked yes must be fully explained in Block 9.)

DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	**YES**	**NO**		**YES**	**NO**
6a. Bee or wasp sting	☐	☐	**6e.** Latex	☐	☐
6b. Hay Fever or seasonal allergies	☐	☐	**6f.** Any drug, e-mycin antibiotic, or sulfa allergies, list in Block 9	☐	☐
6c. Insect bites	☐	☐	**6g.** Other allergies, list in Block 9	☐	☐
6d. Iodine/seafood	☐	☐	**6h.** Food allergies, list in Block 9	☐	☐

7. OVER THE COUNTER MEDICATIONS (These medications may be administered by our staff when requested)

1.	Allergies:	Benadryl
2.	Colds:	Cough Medicine (Robitussin DM, Dimetapp, etc.), Throat/Cough Drops (Chloraseptic, Halls, etc.), Decongestant (Sudafed, etc.)
3.	Constipation:	Milk of Magnesia, Dulcolax, Ex-Lax, or Glycerin Suppository
4.	Cuts and Scraps:	Bacitracin ointment, Betadine, Neosporin ointment
5.	Diarrhea:	Pepto Bismol, Kaopectate, Imodium AD, etc.
6.	Headache	Tylenol or Ibuprofen (Motrin, Advil, Aleve)
7.	Indigestion:	Calcium Carbonate (Tums, Rolaids, etc.)
8.	Itch/Rash:	Cortisone Cream or Calamine Lotion
9.	Sea/Motion Sickness:	Dramamine, Bonine, etc.
10.	Sprains:	Acetaminophen (Tylenol) or Ibuprofen (Motrin, Advil, Aleve)
11.	Sunburn:	Calamine Lotion, Topical Lidocaine Spray or Aloe Vera Gel
12.	Wounds:	Bacitracin ointments, Betadine, Neosporin Ointment

Other medications not listed above may be administered if so recommended by qualified medical staff.
Parents will be contacted directly when over the counter medications need to be administered during unit drills

8. STATEMENT OF UNDERSTANDING AND CONSENT BY INITIALING YOU CERTIFY YOUR UNDERSTANDING & CONSENT TO THE FOLLOWING PARAGRAPHS:	Parent/Guardian Initial Below
8a. I understand that all medications will be administered to the cadet based on dosing instructions on the medication bottle/package. In no instance will cadets be allowed to self-medicate with any over the counter medication.	
8b. I understand and consent that these written instructions may be superseded if, in the opinion of a medical provider, not doing so would place the cadet in a medically compromised condition.	
8c. I understand that If I do not want my child to be administered over the counter medications, or certain medications concurrent with other medications, I must specify those medications or write, "**Do not medicate my child with any over the counter medications**" in Block 9.	

9. REMARKS (please include comments as required by Blocks 4, 6, and/or 8. Also provide any other medical history that you or your physician deems important)

10. AUTHORIZATION AND RELEASE

I certify that, to the best of my knowledge, the information provided is true and accurate and I have disclosed all pertinent medical history. Furthermore, I authorize the Naval Sea Cadet Corps, its agents, officials, and training staff members, to dispense medication listed on this Authorization. I "Hold Harmless" the Naval Sea Cadet Corps from any and all liability, actions, or causes of action for damages or injury that may arise, directly or indirectly, from my child's use of medication while participating in Naval Sea Cadet Corps Activities. I understand that training staff members may not be medical professionals and that medication will be dispensed according to the manufacturer's instructions and/or the instructions I provided on this authorization.

10a. Parent/Guardian Name (Type or Print)	**10b.** Signature	**10c.** Date (DD MMM YY)