

**NOTICE**

Upon enrollment, the information requested below is required to provide 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 medical examiners, in case of injury or illness, while participating in NSCC/NLCC activities. **If taking medications at time of enrollment, list in Block 6.**

**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 officers/midshipmen/instructors/auxiliarists for continued medical fitness before sending on escort duty or other training evolutions.

Commanding Officers (CO) and Commanding Officers of Training Contingents (COTC) retain the obligation to deny acceptance for enrollment or training to any adult if, upon review of this form, it is determined that the adult is not physically/medically qualified for participation.

**1. PERSONAL INFORMATION**

<b>1a.</b> Last Name		<b>1b.</b> First Name		<b>1c.</b> Middle Name		<b>1d.</b> Social Security Number	
<b>1e.</b> Age	<b>1f.</b> Date of Birth (DD MMM YY)	<b>1g.</b> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>1h.</b> Next of Kin Name and Relationship			

**2. MEDICAL PROVIDER/INSURANCE INFORMATION**

<b>2a.</b> Medical Insurance Provider Name		<b>2b.</b> Medical Insurance Policy Number	
<b>2c.</b> Medical Insurance Provider Address		<b>2d.</b> Medical Insurance Provider Phone	
<b>2e.</b> Medical Provider Name		<b>2f.</b> Medical Provider Phone Number	

**3. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in the space provided)**

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO
<b>3a.</b> Tuberculosis or live with someone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>3n.</b> Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>
<b>3b.</b> Chronic or recurrent abdominal or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>3o.</b> Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	<input type="checkbox"/>
<b>3c.</b> Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<b>3p.</b> Car, train, sea, and/or air sickness	<input type="checkbox"/>	<input type="checkbox"/>
<b>3d.</b> Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	<b>3q.</b> A period of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
<b>3e.</b> Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<b>3r.</b> Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>
<b>3f.</b> Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<b>3s.</b> Received counseling for emotional or behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>
<b>3g.</b> Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	<b>3t.</b> Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>
<b>3h.</b> Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	<b>3u.</b> Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
<b>3i.</b> Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3v.</b> Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
<b>3j.</b> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<b>3w.</b> Been hospitalized ( <i>if yes, why, when, where</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>3k.</b> Anemia (including sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3x.</b> Any illness or injury not mentioned above ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>3l.</b> Dizziness or fainting spells (including after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<b>3y.</b> Advised to avoid certain physical activities ( <i>if yes, explain</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>3m.</b> Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b>3z. FEMALES ONLY:</b> At what age did you begin menstrual cycle:		

**3aa.** Describe the condition, time and/or length of occurrence (Include comment if treated, continuing, or life threatening requiring immediate medical attention):

## REPORT OF MEDICAL HISTORY

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

<b>4a.</b> Date of last tetanus or booster	<b>4b.</b> Date of Menactra Vaccine for Meningitis	<b>4c.</b> Date of negative PPD or Medical Provider Clearance for TB
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**5. ALLERGIES** (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 5i.)

DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	YES	NO		YES	NO
<b>5a.</b> Bee or Wasp Sting	<input type="checkbox"/>	<input type="checkbox"/>	<b>5e.</b> Latex	<input type="checkbox"/>	<input type="checkbox"/>
<b>5b.</b> Hay Fever or seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<b>5f.</b> Any drug, E-mycin antibiotic or sulfa allergies, list in Block 5i	<input type="checkbox"/>	<input type="checkbox"/>
<b>5c.</b> Insect Bites	<input type="checkbox"/>	<input type="checkbox"/>	<b>5g.</b> Other Allergies, list in Block 5i	<input type="checkbox"/>	<input type="checkbox"/>
<b>5d.</b> Iodine/seafood	<input type="checkbox"/>	<input type="checkbox"/>	<b>5h.</b> Food allergies, list in Block 5i	<input type="checkbox"/>	<input type="checkbox"/>

**5i.** Describe the allergic reaction and what condition occurs: (Include comment if mild or seasonal, or life threatening requiring immediate medical attention)

**6. REMARKS** (please include any additional comments or any other medical history that you would consider important)

**7. 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 "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 participation in Naval Sea Cadet Corps activities.

<b>7a.</b> Member Name (Type or Print)	<b>7b.</b> Signature	<b>7c.</b> Date (DD MMM YY)
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