Annual Medical Package

CONTENTS:

YMMEDFORM1 Authorization for Medical Treatment

YMMEDFORM2 Health History

YMMEDFORM3 Physical Exam

AUTHORIZATION FOR MEDICAL TREATMENT

PLEASE PRINT (Update for each event requiring medication)

YOUNG MARINE INFORMATION			
Last Name		First Name	Middle Initial
Age	Birthdate (MM/DD/YYYY)	Social Security Number	
Parent/Guardian Name		Relationship	
Home Address Street		City	State / Zip Code
Primary Phone		Secondary Phone	
Work Phone		Email Address	

PART I: MEDICAL CONSENT (Parent or Legal Guardian is required to complete)

I certify that I am the parent, legal guardian, or other person in legal control of the above identified child and request and authorize that by child be administered appropriate first aid and/or taken to the nearest medical facility for emergency treatment as necessary.

Parent or Legal Guardian Signature	Date

PART II: PERMISSION TO USE OVER-THE-COUNTER MEDICATION (If not completed, the Young Marine will not receive medication)

My child identified above has my permission to take any over-the-counter medications in accordance with label instructions as needed with the exception of: while attending Young Marines activities.

Parent or Legal Guardian Signature	Date

PART III: PERMISSION TO DISPENSE PRESCRIPTION MEDICATION (If not completed, the Young Marine will not receive medication)

I request and authorize that my child identified above be administered the following prescription medication:

____

In accordance with the medical doctor's instructions on the original and un-expired label. I certify that my child has a valid reason for taking the medication during Young Marines Activities. This permission is valid from (beginning date) to (ending date) .

Parent or Legal Guardian Signature	Date

PART IV: MEDICATION ADMINISTRATION RECORD

Medication Name	Strength	Form of Medication	
		☐ Liquid ☐ Tablet ☐ Aerosol ☐ Ointment ☐ Other	
Dosage & Time		Date	Administrator/Witness
Medication Name	Strength	Form of Medication ☐ Liquid ☐ Tablet ☐ Aerosol ☐ Ointment ☐ Other	
Dosage & Time		Date	Administrator/Witness
Medication Name	Strength	Form of Medication ☐ Liquid ☐ Tablet ☐ Aerosol ☐ Ointment ☐ Other	
Dosage & Time		Date	Administrator/Witness
Medication Name	Strength	Form of Medication ☐ Liquid ☐ Tablet ☐ Aerosol ☐ Ointment ☐ Other	
Dosage & Time		Date	Administrator/Witness
Medication Name	Strength	Form of Medication ☐ Liquid ☐ Tablet ☐ Aerosol ☐ Ointment ☐ Other	
Dosage & Time		Date	Administrator/Witness

HEALTH HISTORY

PLEASE PRINT

To Be Completed By Parent/Legal Guardian Annually

Note: Your child will NOT be disqualified from the program based on information provided here.

YOUNG MARINE INFORMATION

Last Name		First Name	Middle Initial
Age	Birthdate (MM/DD/YYYY)	Social Security Number	
Parent/Guardian Name			
Primary Physician's Name		Date of Last Visit	
Dentist's Name		Date of Last Visit	

HEALTH HISTORY

Condition	*YES	NO	Remarks (*Yes requires remarks)
Wears eye glasses / contact lenses			
Is on a restricted diet			Specify:
Wears a hearing aid			
Diabetes			Last HbA1c percentage and date:
Is under a doctor's care			
Hypertension (high blood pressure)			
Adult or congenital heart disease / heart attack / chest pain (angina) / heart murmur / coronary artery disease / any heart surgery or procedure / suffered Rheumatic Fever. Explain all "yes" answers.			
Family history of heart disease or any sudden heart-related death of a family member before age 50.			
Stroke/ TIA			
Asthma			Last attack date:
Lung/ respiratory disease			
Ear/ eyes/ nose/ sinus problems			
Muscular/ skeletal condition/ muscle or bone issues			
Head injury/ concussion			
Psychiatric/ psychological or emotional difficulties			
Behavioral/ neurological disorders			
Blood disorders/ sickle cell disease			
Fainting spells and/ or dizziness			
Kidney Disease			
Seizures			Last seizure date:
Abdominal/ stomach/ digestive problems			
Excessive fatigue			
Thyroid Disease			
Obstructive sleep apnea/ sleep disorders			CPAP: Yes No
List all surgeries and hospitalizations			
List any other medical conditions not covered above			

ALLERGIES

Yes	No	Allergies or Reactions	Explain		Yes	No	Allergies or Reactions	Explain
		Medication					Plants	
		Food					Insect stings / bites	

IMMUNIZATION

I certify that the above named child is current on all recommended vaccines and have provided appropriate records to accompany this report OR the Immunization Exemption Request Form has been submitted. Tetanus immunization is required and must have been received within the last 10 years.	Date of Last Tetanus Shot:
	Immunization Waiver Attached: Yes No

I certify the above health history information to be complete, correct, and true to the best of my knowledge.

Parent or Legal Guardian Signature	Date

PHYSICAL EXAMINATION

PLEASE PRINT

To be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician's assistants.
A current school or sports physical may substitute, if done during the current school year. Photocopy must be included in YMRB.

YOUNG MARINE INFORMATION

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YYYY)

You are being asked to certify that this individual has no contraindication for participation in the Young Marines program.
Please fill in the following information:

VITALS

Height	Weight	Blood Pressure	Pulse

EXAMINATION

	Normal	Abnormal	Explain Abnormalities
Eyes/Vision			
Ears/Nose/Throat			
Lungs			
Heart			
Abdomen			
Hernia			
Musculoskeletal			
Neurological			
Other			

RESCTRICTIONS

Provide additional remarks or instructions if participation in the Young Marines is conditional due to any medical conditions not provided in the remarks above.

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined the person identified above and find no contraindications for participating in the Young Marines program. This participant (with noted restrictions):

	True	False	Explain
Does not have uncontrolled heart disease, asthma, seizures, or hypertension.			
Has no uncontrolled psychiatric disorders.			
Does not have poorly controlled diabetes.			

Examiner's Signature		Date of Exam	**VALID ONLY WITH PHYSICIAN'S STAMP**
Print Examiner's Name		Title	
Office Address		Suite	
City	State	Zip	
Office Telephone Number			