

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	CADET APPLICATION REPORT OF MEDICAL EXAM	FOR OFFICIAL USE ONLY																																																			
INSTRUCTIONS																																																					
Acceptance criteria for the Naval Sea Cadet Corps/Navy League Cadet Corps (NSCC/NLCC) are listed on the reverse side. No one will be denied admission to the program due to a medical disability, however participation may be limited if the cadet is not able to meet the medical standards necessary to FULLY participate in training activities involving strenuous physical exercise and activities such as orientation in fighting shipboard fires in often hot and humid environments. The medical provider should list any condition(s) that could interfere with full, unrestricted, participation in the NSCC/NLCC. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illnesses, must be listed. The history of immunization should be verified to the satisfaction of the medical provider. <u>A licensed medical provider must complete this examination.</u>																																																					
1. UNIT INFORMATION																																																					
1a. Unit Name JOHN T DEMPSTER/TRENTON DIV		1b. Region 2																																																			
2. PERSONNEL 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 Physical Examination (DD MMM YY)																																																					
3. CLINICAL EVALUATION																																																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Anatomy</th> <th style="width: 10%;">Normal</th> <th style="width: 20%;">Abnormal</th> </tr> </thead> <tbody> <tr><td>3a. Head, Face, Neck, and Scalp</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3b. Nose</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3c. Sinuses</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3d. Ears – General (<i>Internal and External Canals</i>)</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3e. Drum (<i>Perforation</i>)</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3f. Eyes- General</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3g. Ophthalmoscopic</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3h. Pupils (<i>Equality and Reaction</i>)</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3i. Heart (<i>Thrust, Size, Rhythm, and Sounds</i>)</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3j. Lungs and Chest</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3k. Abdomen and Viscera (<i>Include Hernia</i>)</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3l. External Genitalia (<i>Genitourinary</i>)</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3m. Upper Extremities</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3n. Lower Extremities</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3o. Feet</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>3p. Spine and other Musculoskeletal</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> </tbody> </table>	Anatomy	Normal	Abnormal	3a. Head, Face, Neck, and Scalp	☐	☐	3b. Nose	☐	☐	3c. Sinuses	☐	☐	3d. Ears – General (<i>Internal and External Canals</i>)	☐	☐	3e. Drum (<i>Perforation</i>)	☐	☐	3f. Eyes- General	☐	☐	3g. Ophthalmoscopic	☐	☐	3h. Pupils (<i>Equality and Reaction</i>)	☐	☐	3i. Heart (<i>Thrust, Size, Rhythm, and Sounds</i>)	☐	☐	3j. Lungs and Chest	☐	☐	3k. Abdomen and Viscera (<i>Include Hernia</i>)	☐	☐	3l. External Genitalia (<i>Genitourinary</i>)	☐	☐	3m. Upper Extremities	☐	☐	3n. Lower Extremities	☐	☐	3o. Feet	☐	☐	3p. Spine and other Musculoskeletal	☐	☐	NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment)	
Anatomy	Normal	Abnormal																																																			
3a. Head, Face, Neck, and Scalp	☐	☐																																																			
3b. Nose	☐	☐																																																			
3c. Sinuses	☐	☐																																																			
3d. Ears – General (<i>Internal and External Canals</i>)	☐	☐																																																			
3e. Drum (<i>Perforation</i>)	☐	☐																																																			
3f. Eyes- General	☐	☐																																																			
3g. Ophthalmoscopic	☐	☐																																																			
3h. Pupils (<i>Equality and Reaction</i>)	☐	☐																																																			
3i. Heart (<i>Thrust, Size, Rhythm, and Sounds</i>)	☐	☐																																																			
3j. Lungs and Chest	☐	☐																																																			
3k. Abdomen and Viscera (<i>Include Hernia</i>)	☐	☐																																																			
3l. External Genitalia (<i>Genitourinary</i>)	☐	☐																																																			
3m. Upper Extremities	☐	☐																																																			
3n. Lower Extremities	☐	☐																																																			
3o. Feet	☐	☐																																																			
3p. Spine and other Musculoskeletal	☐	☐																																																			
4. LABORATORY FINDINGS (<i>only required for those with a history of urinary tract infections or anemia, enter N/A if tests were not administered</i>)																																																					
4a. Urinalysis (1) Albumin: _____ (2) Sugar: _____		4b. Blood (1) Hemoglobin: _____ (2) Hematocrit: _____																																																			
5. MEASUREMENTS AND OTHER FINDINGS																																																					
5a. Height inches	5b. Weight lbs.	5c. Obese ☐ Yes ☐ No																																																			
5d. Pulse		5e. Blood Pressure (1) Systolic: _____ (2) Diastolic: _____																																																			
5f. Audiogram (if available) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">HZ</th> <th style="width: 10%;">500</th> <th style="width: 10%;">1000</th> <th style="width: 10%;">2000</th> <th style="width: 10%;">3000</th> <th style="width: 10%;">4000</th> <th style="width: 10%;">6000</th> </tr> </thead> <tbody> <tr> <td>Right</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Left</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>		HZ	500	1000	2000	3000	4000	6000	Right							Left							5g. Wears Glasses ☐ Yes ☐ No																														
HZ	500	1000	2000	3000	4000	6000																																															
Right																																																					
Left																																																					
		5h. Wears Contacts ☐ Yes ☐ No																																																			
		5i. Uncorrected Vision (1) Left: 20/ _____ (2) Right: 20/ _____																																																			
5j. Color Vision																																																					
5k. Other Findings (if more room is needed, continue on reverse)																																																					

		REPORT OF MEDICAL EXAM			
6. CLINICAL SCREENING (Please check if the patient has any of the following conditions and whether it will affect the ability to participate in NSCC/NLCC activities.)					
Condition(s)	Pre-Existing	NOTES: (Describe every condition in detail. Enter pertinent item number before each comment)			
6a. Seizure or convulsion disorder	☐ Yes ☐ No				
6b. Asthma	☐ Yes ☐ No				
6c. Symptomatic/recurring orthopedic injury	☐ Yes ☐ No				
6d. Diabetes, Type I	☐ Yes ☐ No				
6e. Diabetes, Type II	☐ Yes ☐ No				
6f. Hypersensitivity to Food	☐ Yes ☐ No				
6g. Insect bites/stings sensitivity	☐ Yes ☐ No				
6h. Head injuries resulting in residual impairment	☐ Yes ☐ No				
6i. Neurological Impairment	☐ Yes ☐ No				
6j. History of recurring loss of consciousness	☐ Yes ☐ No				
6k. History of debilitating motion sickness	☐ Yes ☐ No				
6l. Sleepwalking	☐ Yes ☐ No				
6m. Bedwetting	☐ Yes ☐ No				
7. NOTES, REMARKS, AND OTHER FINDINGS (Use additional sheets of paper if needed)					
8. MEDICAL PROVIDER ENDORSEMENT (Check all that apply):					
I have reviewed the data above, reviewed the patient's medical history form and make the following recommendations for his/her participation in the NSCC/NLCC					
8a. ☐ CLEARED WITHOUT RESTRICTIONS					
8b. ☐ Cleared AFTER further evaluation or treatment for:					
8c. ☐ Cleared for LIMITED participation					
☐ Not cleared for (specify activities): ☐ Cleared only for (specify activities): Reasons:					
8d. ☐ NOT CLEARED FOR PARTICIPATION					
Reasons:					
8e. ☐ OTHER RECOMMENDATIONS					
☐ Recommend close monitoring during conditioning because of weight/fitness/other. ☐ Recommend restrictions or monitoring of weight loss/gain or fitness concerns. ☐ Recommend participation under following condition(s): ☐ Other:					
9. MEDICAL PROVIDER					
9a. Name of Medical Provider (Type or Print) or Medical Provider Stamp			9b. Signature (MD, DO, NP, PA)		9c. Date (DD MMM YY)
9b. Medical Provider Address		9c. City	9c. State	10c. Zip Code +4	9c. Phone