

**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. A licensed medical provider must complete this examination.

**1. UNIT INFORMATION**

<b>1a. Unit Name</b> Ghostriders Squadron	<b>1b. Region</b> 096
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**2. PERSONNEL INFORMATION**

<b>2a. Last Name</b>	<b>2b. First Name</b>	<b>2c. MI</b>	<b>2d. Social Security Number</b>
<b>2e. Age</b>	<b>2f. Date of Birth (DD MMM YY)</b>	<b>2g. Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>2h. Parent/Guardian Name</b>
<b>2i. Home Address</b>		<b>2j. City</b>	<b>2k. State</b> <b>2l. Zip Code + 4</b>
<b>2m. Primary Phone</b>		<b>2n. Alternate Phone</b>	<b>2o. Date of Physical Examination (DD MMM YY)</b>

**3. CLINICAL EVALUATION**

Anatomy	Normal	Abnormal	NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment)
<b>3a. Head, Face, Neck, and Scalp</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3b. Nose</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3c. Sinuses</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3d. Ears – General (Internal and External Canals)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3e. Drum (Perforation)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3f. Eyes- General</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3g. Ophthalmoscopic</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3h. Pupils (Equality and Reaction)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3i. Heart (Thrust, Size, Rhythm, and Sounds)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3j. Lungs and Chest</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3k. Abdomen and Viscera (Include Hernia)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3l. External Genitalia (Genitourinary)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3m. Upper Extremities</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3n. Lower Extremities</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3o. Feet</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3p. Spine and other Musculoskeletal</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**4. LABORATORY FINDINGS (only required for those with a history of urinary tract infections or anemia, enter N/A if tests were not administered)**

<b>4a. Urinalysis</b> (1) Albumin: _____ (2) Sugar: _____	<b>4b. Blood</b> (1) Hemoglobin: _____ (2) Hematocrit: _____
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**5. MEASUREMENTS AND OTHER FINDINGS**

<b>5a. Height</b> inches	<b>5b. Weight</b> lbs.	<b>5c. Obese</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>5d. Pulse</b>	<b>5e. Blood Pressure</b> (1) Systolic: _____ (2) Diastolic: _____
<b>5f. Audiogram (if available)</b>				<b>5g. Wears Glasses</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HZ</b>	<b>500</b>	<b>1000</b>	<b>2000</b>	<b>3000</b>
<b>4000</b>	<b>6000</b>	<b>5h. Wears Contacts</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>5i. Uncorrected Vision</b> (1) Left: 20/ _____ (2) Right: 20/ _____
<b>Right</b>				
<b>Left</b>				<b>5j. Color Vision</b>

**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)
<b>6a.</b> Seizure or convulsion disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6b.</b> Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6c.</b> Symptomatic/recurring orthopedic injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6d.</b> Diabetes, Type I	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6e.</b> Diabetes, Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6f.</b> Hypersensitivity to Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6g.</b> Insect bites/stings sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6h.</b> Head injuries resulting in residual impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6i.</b> Neurological Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6j.</b> History of recurring loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6k.</b> History of debilitating motion sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6l.</b> Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6m.</b> Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> 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**

<b>9a.</b> Name of Medical Provider (Type or Print) or Medical Provider Stamp	<b>9b.</b> Signature (MD, DO, NP, PA)	<b>9c.</b> Date (DD MMM YY)
<b>9b.</b> Medical Provider Address	<b>9c.</b> City	<b>9c.</b> State
	<b>10c.</b> Zip Code +4	<b>9c.</b> Phone