

**UNITED STATES ARMY CADET CORPS
REPORT OF MEDICAL HISTORY AND EXAMINATION**
For use of this form, see ACR 601-210; the proponent directorate is the G1

AUTHORITY: AC Regulation 601-210, Enrollment Standards and Procedures.

PRINCIPAL PURPOSE: The information requested below is required to provide the examining physician with an accurate history of illnesses or injuries that may affect your child's ability to perform strenuous physical exercise and exposure to military living and working environments that are a part of participating as a member in the United States Army Cadet Corps. The information provided must be accurate and complete. You are strongly encouraged to consult with your child's personal physician regarding any past illnesses or injuries. Proof of immunization for Polio, Measles, Mumps, Rubella and Diphtheria, Pertussis and Tetanus (DPT) plus Diphtheria and Tetanus (dt) booster must be provided to the examining physician.

ROUTINE USES: The information contained in this form becomes a part of the Cadet's CADTRAK record and Field Personnel File. All uses of the form are internal to the United States Army Cadet Corps.

CADET IDENTIFICATION DATA

NAME (Last, First, Middle) SSN

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

Has/Does your Child: (Please explain any "yes" answers, noting the number of the question(s), on a separate sheet)

(answer all questions)		YES	NO	(answer all questions)		YES	NO
1. Had Chicken Pox?				18. Ever had seizures?			
2. Had the Measles?				19. Ever had chest pain during or after exercise?			
3. Had German Measles?				20. Ever had high blood pressure?			
4. Had the Mumps?				21. Ever been diagnosed with a heart murmur?			
5. Had Hepatitis?				22. Ever had back problems?			
6. Had Varicella Zoster?				23. Ever had problems with joints (e.g., knees, ankles)?			
7. Had any recent injury, illness or infectious disease?				24. Have an orthodontic appliance?			
8. Have chronic or recurring illness/condition?				25. Have any Skin problems (e.g., itching, rash, acne)?			
9. Ever been hospitalized?				26. Have diabetes?			
10. Ever had surgery?				27. Have asthma?			
11. Have frequent headaches?				28. Had mononucleosis in the past 12 months?			
12. Ever had a head injury?				29. Had problems with diarrhea/constipation?			
13. Ever been knocked unconscious?				30. Have problems with sleepwalking?			
14. Wear Glasses, contacts or protective eye wear?				31. If female, have an abnormal menstrual history?			
15. Ever had frequent ear infections?				32. Have a history of bed wetting?			
16. Ever passed out during or after exercise?				33. Have an eating disorder?			
17. Ever been dizzy during or after exercise?				34. Had emotional difficulties for which professional help was sought?			

Other problems/conditions not listed (explain):

Does your child take any medication(s) regularly? If yes, what medication(s) and why?

Yes No

IMMUNIZATION HISTORY
(month/day/year)

	1	2	3	4	5
DTaP, DPT, DT, Td	/ /	/ /	/ /	/ /	/ /
Polio Vaccine	/ / /	/ / /	/ / /	/ / /	/ / /
MMR (Measles/Mumps/Rubella)	/ / /	/ / /	/ / /	/ / /	/ / /
Hib (Haemophilus Influenza B)	/ / /	/ / /	/ / /	/ / /	/ / /
Hepatitis B	/ / /	/ / /	/ / /	/ / /	/ / /
Varicella	/ / /	/ / /	/ / /	/ / /	/ / /
Other Vaccines:	/ / /	/ / /	/ / /	/ / /	/ / /
TB Mantoux test	/ / /	Result:	/ / /	Result:	/ / /

I CERTIFY THAT THE HEALTH AND IMMUNIZATION HISTORY ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Custodial Parent's Signature:

REPORT OF MEDICAL EXAMINATION BY A LICENSED MEDICAL PRACTITIONER (M.D., D.O., P.A. or NP)

TO THE EXAMINING PHYSICIAN: Please review this applicant's history and complete the physician's report below. Medical clearance for acceptance into the United States Army Cadet Corps is based solely upon the applicant's ability to participate in strenuous physical activity consistent with military living and working environments, as well as extensive physical exercise similar to what would be experienced during military recruit training. Special attention should be given to cardiovascular and orthopedic conditions. The immunization history should be verified. Conditions that are considered disqualifying include, but are not limited to, symptomatic or recurrent orthopedic complaints; allergies or hypersensitivity to foods, medications, or insect bites/stings; history of asthma; seizures or convulsions; head injuries requiring hospitalization; loss of consciousness; diabetes requiring dietary restrictions or medication; history of chronic motion sickness, sleep walking or bed wetting since age 9. Laboratory findings and pelvic examination are at the discretion of the Licensed Medical Practitioner. Candidates with defective vision sufficient enough to preclude them from activities requiring removal of glasses (or contacts) shall be reviewed on a case-by-case basis. Physicians should submit statements for consideration of acceptance when a pre-existing condition exists that, in the opinion of the medical examiner, will not become aggravated nor will any restrictions result from said condition.

CLINICAL EVALUATION

NORMAL	<i>(Check each item in appropriate column; enter NE if not evaluated.)</i>	ABNORMAL
1. HEAD, FACE, NECK AND SCALP		
2. NOSE		
3. SINUSES		
4. MOUTH AND THROAT		
5. EARS – GENERAL		
6. DRUMS <i>(Perforation)</i>		
7. EYES – GENERAL		
8. OPHTHALMOSCOPIC		
9. PUPILS <i>(Equality and reaction)</i>		
10. OCULAR MOTILITY <i>(Associated parallel movements, nystagmus)</i>		
11. LUNGS AND CHEST <i>(Include breasts)</i>		
12. HEART		
13. VASCULAR SYSTEM <i>(Varicosities, etc.)</i>		
14. ABDOMEN AND VISCERA <i>(Include hernia)</i>		
15. ANUS AND RECTUM <i>(Hemorrhoids, fistulae)(Prostate, if indicated)</i>		
16. ENDOCRINE SYSTEM		
17. G- U SYSTEM		
18. UPPER EXTREMITIES <i>(Strength range in motion)</i>		
19. FEET		
20. LOWER EXTREMITIES <i>(Except Feet) (Strength range in motion)</i>		
21. SPINE, OTHER MUSCULOSKELETAL		
22. IDENTIFYING BODY MARKS, SCARS, TATTOOS <i>(Circumcision, etc.)</i>		
23. SKIN, LYMPHATICS		
24. NEUROLOGIC		
25. PSYCHIATRIC <i>(Specify and personality deviation)</i>		
26. Pelvic <i>(females only) (Check how done)</i> <input type="checkbox"/> Vaginal <input type="checkbox"/> Rectal		

NOTES *(Describe every abnormality in detail. Enter pertinent item number before each comment. Add attachment if necessary)*

LABORATORY FINDINGS

URINALYSIS		SEROLOGY	
A. SPECIFY GRAVITY	C. SUGAR	HEMOGLOBIN	BLOOD TYPE
B. ALBUMIN	D. MICROSCOPIC	HEMOCRIT	RH FACTOR

MEASUREMENT AND OTHER FINDINGS

HEIGHT	WEIGHT	COLOR HAIR	COLOR EYES	BUILD <input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE	TEMPERATURE
BLOOD PRESSURE (ARM AT HEART LEVEL)		PULSE (ARM AT HEART LEVEL)		UNCORRECTED VISION:	
A	SYS	B	SYS	SITTING	AFTER EXERCISE
	DIAS		DIAS		
SITTING		RECUMBENT			
				20/	20/

SUMMARY OF DEFECTS AND DIAGNOSES

EXAMINEE *(CHECK ONE)*
 IS QUALIFIED IS NOT QUALIFIED

IF NOT QUALIFIED, LIST DEFECTS BY ITEM NUMBER OR DESCRIPTION

TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE	DATE
TYPED OR PRINTED NAME OF REVIEWING OFFICER	SIGNATURE	DATE