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. A licensed medical provider must complete this examination.

1. UNIT INFORMATION

1a. Unit Name	**1b.** Region
AKRON BATTALION	AKR 058

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

Anatomy	Normal	Abnormal
3a. Head, Face, Neck, and Scalp	☐	☐
3b. Nose	☐	☐
3c. Sinuses	☐	☐
3d. Ears – General *(Internal and External Canals)*	☐	☐
3e. Drum *(Perforation)*	☐	☐
3f. Eyes- General	☐	☐
3g. Ophthalmoscopic	☐	☐
3h. Pupils *(Equality and Reaction)*	☐	☐
3i. Heart *(Thrust, Size, Rhythm, and Sounds)*	☐	☐
3j. Lungs and Chest	☐	☐
3k. Abdomen and Viscera *(Include Hernia)*	☐	☐
3l. External Genitalia *(Genitourinary)*	☐	☐
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)

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

4a. Urinalysis		**4b.** Blood	
(1) Albumin:	(2) Sugar:	(1) Hemoglobin:	(2) Hematocrit:

5. MEASUREMENTS AND OTHER FINDINGS

5a. Height	**5b.** Weight	**5c.** Obese	**5d.** Pulse	**5e.** Blood Pressure	
inches	lbs.	☐ Yes ☐ No		(1) Systolic:	(2) Diastolic:

5f. Audiogram (if available)

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

5g. Wears Glasses	**5h.** Wears Contacts	**5i.** Uncorrected Vision	
☐ Yes ☐ No	☐ Yes ☐ No	(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