MARION MILITARY INSTITUTE

Medical History Form (To be completed by Cadet and/or Parent)

NAME:_____ SEX at Birth: _____AGE:_____ Date of BIRTH:_____

ADDRESS:_____ CELL PHONE:_____

Explain 'YES" answers below	YES	NO
1. Has a doctor or medical provider ever restricted/denied your participation in sports or physical training?		
2. Have you ever been hospitalized or spent the night in a hospital?		
3. Do you have any ongoing medical conditions (like Asthma, diabetes, high blood pressure joint or bone injuries)?		
4. Are you currently taking any medications or pills (prescription or over the counter), if yes list in item 20?		
5.Do you have any allergies (medicine, pollens, foods, bees, or other stinging insects)? If yes list in item 20?		
6. Have you ever passed out during or after exercise?		
Have you ever had chest pain or discomfort in your chest during or after exercise		
Do you tire more quickly than your friends during exercise?		
Have you ever had high blood pressure?		
Have you ever been old that you have a heart murmur, high cholesterol, or heart infection?		
Have you ever had racing of your heart or skipped heartbeats?		
Has anyone in your family died of heart problems or sudden death before age 50?		
Does anyone in your family have a heart condition? Who_____		
Has a doctor ever ordered a test on your heart (EKG, Echocardiogram)?		
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne, or facial shaving bumps)?		
8. Have you ever had a head injury or concussion?		
Have you ever been knocked out or unconscious?		
Have you ever had a seizure?		
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?		
9. Have you ever had heat or muscle cramps to include shin splints?		
Have you ever been dizzy or passed out in the heat?		
10. Do you have any trouble breathing or do you cough during or after exercise?		
Do you take any medications for asthma (inhalers, oral meds, breathing treatments)?		
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guard, joint stabilizers etc)?		
12. Have you had any problems with your eyes or vision?		
13. Do you wear glasses or contacts or protective eye wear?		
14. Have you had any other medical problems (Infectious mononucleosis, diabetes, covid-19, Infectious diseases, etc)?		
15. Have you had a medical problem or injury since your last medical evaluation? If yes explain:_____		
16. Have you ever been told you have sickle cell or sickle cell trait?		
17. Does anyone in your family have sickle cell disease or sickle cell trait?		
18. Have you ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any bones or joints? ( ) Head ( )Back ( ) Shoulder ( )Forearm ( ) Hand ( ) Hip ( ) Knee ( ) Ankle ( ) Neck ( ) Chest ( )Elbow ( ) Wrist ( ) Finger ( ) Thigh ( ) Shin ( ) Foot		
Female Students: 19. When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year _____		
20. Explain all "YES" answers in below space(s) If more space is needed =, please attach a separate document.		

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

Signature of Student:_____Date:_____

Signature of Parent/Guardian (if cadet is under 18)_____ Date:_____

Marion Military Institute

Mandatory Cadet and Athlete Physical

Page 2 and 3 to be completed by MD, DO, PA, or NP only

Pre- Participation Physical* Required for all cadets **(to be completed by no more than 60 days PRIOR to ARRIVAL on CAMPUS)** and for student athletes once each calendar year per the National Junior College Athletic Association (NJCAA) guidelines. Note: **Exam must be performed and signed by a Physician (MD, DO, PA or NP ONLY**, a chiropractor is not acceptable for this physician.

Name: _____ **D.O.B.:**_____ **SSN:**_____ **Gender at Birth:**_____

Height:_____ **Weight:** _____**Blood Pressure:** _____ **Pulse:** _____ **Respirations:** _____ **Glasses or Contacts:** _____

Vision: Right 20/_____ **Left 20/**_____ **Corrected Vision: Yes or No** **Comments:** _____

Examination	Normal	Abnormal	If Abnormal, please explain	Initials
Appearance				
Skin				
Head and neck				
Eyes/Ears/ Nose				
Teeth/Mouth/Throat				
Lungs/Chest				
Cardiovascular/ Heart				
Abdomen/Lymphatic/ Gastrointestinal				
Genitalia				
Inguinal Hernia				
Overweight/Obese/Morbid Obesity				
Neurological				
Musculoskeletal				
Back				
Shoulders/Arms				
Wrists/hands/Fingers				
Hips/Thighs				
Knees				
Legs/Ankles/Feet/Toes				
Other				
Braces				
Mental/Emotional				

College Program: ROTC/ECP_____ AF ROTC_____NROTC_____SAP_____ LEP_____ PLC_____ First Responder/Law Enforcement_____

LEP Non Athlete:_____ LEP Athlete (Which Sport will you be playing at MMI):_____

Activities at Marion Military Institute each Cadet must be able to fully participate in are:

1) **Obstacle Courses involving running, jumping, climbing/scaling and lifting.**
2) **A two-mile run for time.**
3) **Maximum pushups/planks for time.**
4) **Maximum Sit-ups for time.**
5) **Standing at attention in formation for extended periods of time.**
6) **10-mile march with or without added weight on hard surfaces.**
7) **Marching with a rifle for up to 1-hour at a time for maximum of 6 hours.**
8) **Daily Physical Fitness Training (calisthenics, weights, cardio and repetitive movement).**

I CERITFY THAT I HAVE REVIEWED THE HEALTH HISTORY, EXAMINIED THIS PERSON AND APPROVED THIS INDIVIDUAL FOR PARTICIPATION IN THE ABOVE LISTED ACTIVITES:

____Cadet Applicant is Cleared to participate in full unrestricted military activities (as described above)	HCP Printed Name:_____ (MD/DO/NP/PA-C) only
___ Cadet Applicant in NOT cleared to participate Reason: _____ _____ _____ _____	Signature:_____ Address:_____ City/State/ Zip:_____ Office phone:_____ Date:_____

MEDICAL FITNESS STATEMENT FOR ENROLLMENT IN BASIC COURSE, SENIOR ROTC FOR USE OF THIS FORM, SEE AR 145-1, THE PROPONENT IS ODSCEPER	DATE:
I HAVE EXAMINED_____, and find NO medical condition or physical impairment that precludes his/her participation in the basic course, ARMY ROTC, a program not more physical or strenuous than a normal college physical education program.	
Signature of Physician (My signature certifies that the above-named student cadet is medically fit to participate in all physical requirements, without any physical limitations at Marion Military Institute _____	DATE:

DA Form 3425-R 1SEP 68

STUDENT and PARENT to Sign:

I understand that my failure to disclose all current and previous physical, medical and mental conditions will be grounds for termination of my cadet career with forfeiture of appropriate tuition and fees, ***Marion Military Institute*** will NOT be held liable for any injuries that a cadet may sustain as a result of these factors. This applies to active conditions which could affect participation in military, athletic and/or academic programs, as well as past medical and psychiatric conditions.

Student /Cadet Signature: _____Date:_____

Parent Signature: (required if cadet is under 19 years of age)_____ Date:_____

Medications: List all Medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen Information MUST be included, even if they are for occasional or emergency use only.

Medication: Strength:_____ Frequency:_____ Reason for Medication: _____ _____ Date Started: _____ ___Temporary ___ Permanent	Medication: Strength:_____ Frequency:_____ Reason for Medication: _____ _____ Date Started: _____ ___Temporary ___ Permanent	Medication: Strength:_____ Frequency:_____ Reason for Medication: _____ _____ Date Started: _____ ___Temporary ___ Permanent	Medication: Strength:_____ Frequency:_____ Reason for Medication: _____ _____ Date Started: _____ ___Temporary ___ Permanent
Medication: Strength:_____ Frequency:_____ Reason for Medication: _____ _____ Date Started: _____ ___Temporary ___ Permanent	Medication: Strength:_____ Frequency:_____ Reason for Medication: _____ _____ Date Started: _____ ___Temporary ___ Permanent	Medication: Strength:_____ Frequency:_____ Reason for Medication: _____ _____ Date Started: _____ ___Temporary ___ Permanent	Be sure to bring all medications in the original containers and make sure they are NOT expired, including inhalers and EpiPen(s) (approved). You should not stop taking any maintenance medications. If applicable, ensure you bring two pairs of glasses and prescriptions.

Allergies

Allergies/Type	___Food ___Biting/sting insects ___Medications ___Latex _Other __None Type of reaction_____ Treatment Required:_____