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 <u>FULLY</u> 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.

4 LINIT INFORMATION								
provider. A licensed medical provider must complete this examination. 1. UNIT INFORMATION								
1a. Unit Name1b. Region	1							
2. PERSONNEL INFORMATION								
2a. Last Name 2b. First Name 2c. MI 2d. USNSCC ID N	umber							
2e. Age 2f. Date of Birth (DD MMM YY) 2g. Sex 2h. Parent/Guardian Name								
2i. Home Address2j. City2k. State2l. Zip Code + 4	2k. State 2l. Zip Code + 4							
2m. Primary Phone 2n. Alternate Phone 2o. Date of Physical Examination (DD MMN)	ate of Physical Examination (DD MMM YY)							
3. CLINICAL EVALUATION								
Anatomy Normal Abnormal NOTES: (Describe every abnormality in detail. Enter pertinent item number before each	comment)							
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)								
3I. External Genitalia (Genitourinary)								
3m. Upper Extremities								
3n. Lower Extremities	nities — — —							
3o. Feet								
3p. Spine and other Musculoskeletal								
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	5e. Blood Pressure							
inches Ibs. Yes No (1) Systolic: (2) Diastolic:	(2) Diastolic:							
5f. Audiogram (if available) 5g. Wears Glasses 5h. Wears Contacts 5i. Uncorrected Vision								
HZ 500 1000 2000 3000 4000 6000 Yes No Yes No (1) Left: 20/ (2) Right: 21)/							
Right Sj. Color Visidal L								
5k. Other Findings (if more room is needed, continue on reverse)								

	F	REPORT	OF MEDICAL	EXAM			
6. CLINICAL SCREENING (Please check if the patier	nt has any	of the followin	g conditions and whether	it will affect the	ability to participate in N	SCC/NLCC activities.)	
Condition(s)	Pre-l	Existing	NOTES: (Describe every c	ondition in detail. E	Enter pertinent item number b	pefore 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]				
6I. Sleepwalking	Yes	No]				
6m. Bedwetting	Yes	□ No]				
7. NOTES, REMARKS, AND OTHER FINDINGS (Us	e additiona	I sheets of pa	per if needed)				
8. MEDICAL PROVIDER ENDORSEMENT (Check at I have reviewed the data above, reviewed the patient 8a. CLEARED WITHOUT RESTRICTIONS 8b. Cleared AFTER further evaluation or to 10 cleared for LIMITED participation 10 Not cleared for (specify activities 10 cleared only for (specify activities	's medical S reatment for	history form a	nd make the following rec	ommendations	for his/her participation ir	n the NSCC/NLCC	
8d. NOT CLEARED FOR PARTICIPATION	N						
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 Medi	cal Provide	r 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	