

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS	<h1 style="margin: 0;">REPORT OF MEDICAL EXAM</h1>	FOR OFFICIAL USE ONLY
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INSTRUCTIONS

Acceptance criteria for applicants 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 examiner 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 illness must be listed. The history of immunization should be verified to the satisfaction of the medical examiner. A licensed medical provider must complete this examination.

1. UNIT INFORMATION	
1a. Unit Name NCBC BATTALION, QUONSET POINT RI	1b. Region 1-4

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

4. CLINICAL EVALUATION			
Anatomy	Normal	Abnormal	NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment)
4a. Head, Face, Neck, and Scalp	<input type="checkbox"/>	<input type="checkbox"/>	
4b. Nose	<input type="checkbox"/>	<input type="checkbox"/>	
4c. Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	
4d. Ears – General (<i>Internal and External Canals</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
4e. Drum (<i>Perforation</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
4f. Eyes- General	<input type="checkbox"/>	<input type="checkbox"/>	
4g. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>	
4h. Pupils (<i>Equality and Reaction</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
4i. Heart (<i>Thrust, Size, Rhythm, and Sounds</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
4j. Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>	
4k. Abdomen and Viscera (<i>Include Hernia</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
4l. External Genitalia (<i>Genitourinary</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
4m. Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
4n. Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
4o. Feet	<input type="checkbox"/>	<input type="checkbox"/>	
4p. Spine and other Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	

5. LABORATORY FINDINGS (<i>only required for those with a history of urinary tract infections or anemia, enter N/A if tests were not administered</i>)			
5a. Urinalysis (1) Albumin: _____ (2) Sugar: _____	5b. Blood (1) Hemoglobin: _____ (2) Hematocrit: _____		

6. MEASUREMENTS AND OTHER FINDINGS									
6a. Height inches	6b. Weight lbs.	6c. Obese <input type="checkbox"/> Yes <input type="checkbox"/> No	6d. Pulse	6e. Blood Pressure (1) Systolic: _____ (2) Diastolic: _____					
6f. Audiogram (if available)						6g. Wears Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No	6h. Wears Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No	6i. Uncorrected Vision (1) Left: 20/ _____ (2) Right: 20/ _____	
HZ	500	1000	2000	3000	4000	6000	6k. Color Vision		
Right									
Left									

6l. Other Findings (if more room is needed, continue on reverse)

REPORT OF MEDICAL EXAM

7. 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)
7a. Seizure or convulsion disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7b. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7c. Symptomatic/recurring orthopedic injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7d. Diabetes, Type I	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7e. Diabetes, Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7f. Hypersensitivity to Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7g. Insect bites/stings sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7h. Head injuries resulting in residual impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7i. Neurological Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7j. History of recurring loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7k. History of debilitating motion sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7l. Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7m. Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	

8. NOTES, REMARKS, AND OTHER FINDINGS (Use additional sheets of paper if needed)

9. 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

9a. **CLEARED WITHOUT RESTRICTIONS**

9b. Cleared **AFTER** further evaluation or treatment for:

9c. Cleared for **LIMITED** participation

Not cleared for (specify activities):

Cleared only for (specify activities):

Reasons:

9d. **NOT CLEARED FOR PARTICIPATION**

Reasons:

9e. **OTHER RECOMMENDATIONS**

Recommend close monitoring during conditioning because of weight/fitness/other.

Recommend restrictions or monitoring of weight loss/gain or fitness concerns.

Recommend participations under following condition(s):

Other:

10. MEDICAL PROVIDER

10a. Name of Medical Provider (Type or Print) or Medical Provider Stamp

10b. Signature (MD, DO, PN, PA)

10c. Date (DD MMM YY)

10b. Medical Provider Address

10c. City

10c. State

10c. Zip Code +4

10c. Phone