Medical Evaluation and Immunization Records

MMA Health Services – Infirmary
540-459-0425 Fax: 540-459-7642

To Be Completed by **Physician**

Cadet's Name:_____ Birth date: ____/___ /____
Last name First Middle (initial)

Allergies:_____

Type of Reaction:_____

Sex: _____ Height: _____ Weight: _____ Blood Pressure: _____

*Please indicate any **abnormalities** of the following systems. Describe/explain fully, as appropriate, on the reverse side of this form.*

	Yes	No
General Appearance		
Skin		
Head		
Eyes		
Ears		
Nose		
Throat		
Mouth/Teeth		

	Yes	No
Cardiovascular		
Hernia/Tanner Stage		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Respiratory		
Gastrointestinal		
Genitourinary		

	Yes	No
Ankles		
Knees		
Feet		
Back		
Shoulders		
Neck		
Chest		
Other		

Is this cadet (student) physically fit for participation in competitive sports and military programs? ___ Yes ___ No
If no, please specify why not:

REQUIRED IMMUNIZATIONS – Please indicate the month, day, and year on which vaccine doses were given.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTP/DTaP (3 doses minimum with one dose after 4th birthday)					
Tdap (for 7th grade enrollment, if 5 years since last DTP/Td)					
Poliomyelitis (3 doses minimum with 1 dose after 4th birthday)					
MMR (2 doses minimum with 1 dose after 4th birthday)					
Hepatitis B (3 doses)					
Varicella (2 doses or date of disease or serological confirmation)			Date of disease, or serological confirmation:		
PPD (*if required per TB infection risk*)	Date Planted:		Date Read:		Result:
Meningococcal Vaccine (Recommended)					

PRESCRIBED CURRENT MEDICATIONS

Medication	Dosage	Schedule Time Taken During the Day/Evening	Frequency per Day

MEDICATIONS TAKEN OVER PAST FIVE YEARS

Medication	Dosage	Schedule Time Taken During the Day/Evening	Frequency per Day

Physician's Statement

I have completed this medical evaluation. Further, as the physician prescribing the medications listed above, I hereby authorize the Academy's Infirmary staff to dispense medications as I have prescribed and as permitted by the cadet's parent/guardian(s). I acknowledge that ***changes in medications or dosages require my written confirmation to the Infirmary staff.***

_____

Physician's Signature **Physician's phone #** **Date of Examination**

_____ _____

Physician's Name, printed

_____

Contact information