The Citadel Infirmary

Incoming Cadets and Parents:

1. Please complete the attached **Medical Information**, **Medical History**, and **Insurance** forms, and ask your physician (MD or DO) to complete the **Physical Examination** and **Immunization** forms. Positive answers on the History & Physical forms must be fully explained, both to determine whether you meet physical qualifications for The Citadel and to guide the Infirmary staff in providing care should you become ill or injured while a cadet. If you have already completed a DODMERB physical, please see section 4, below.

2. **Medical forms** are due by ***May 1st***. Forms will not be accepted after the class is full, even if that is before the 1 May cutoff. In some cases, we may ask for additional medical or surgical information, based on your history & physical exam forms. Some conditions will require a note from your doctor clearing you for unrestricted physical activity. When requested, ***supplemental medical information*** (doctor's summary, clearance to participate in all activities, etc.) must be provided as soon as possible, but absolutely no later than ***July 1st***. Your application will not be complete until we receive all the requested information. You will be considered medically disqualified after July 1st unless we receive all necessary information.

3. **Medical clearance** for an applicant to attend The Citadel is based on Department of Defense standards. However, we can approve **waivers** for some minor disqualifying medical conditions. Mild asthma, occasional migraine headaches, ADD/ADHD, and mild depression or anxiety are among the common conditions which can be waived. If you have questions about whether a medical condition is waiverable, please contact Dr. Capell by e-mail (carey.capell@citadel.edu) or call the number below as early as possible. If you are denied admission to The Citadel because of a medical disqualification, your deposit will be refunded.

4. If you have already had a **DODMERB** physical, we do accept the DD Form 2351, "DODMERB Report of Medical Examination," and DD Form 2492, "DODMERB Report of Medical History," in place of the Citadel physical exam and history forms. All other Citadel forms ("Medical Information," "Medical Insurance," and "Immunizations") must be submitted along with the DD Forms. The DD forms **must** include height, weight, vision, and blood pressure. It is the student's responsibility to obtain a copy of their DODMERB to submit to The Citadel Infirmary.

5. If you develop a **significant illness** or **injury** after submitting your medical forms, please ask your doctor to send a short, interim report describing your current medical status and anticipated status at matriculation. These **Interim reports** must be received *as soon as possible* after the illness or injury; your application will not be complete until we receive them.

6. Please note that failure to report significant pre-existing **medical** or **psychiatric conditions** will be *grounds for termination* of your cadet career, with forfeiture of tuition and fees. This applies to active conditions which could affect participation in military, athletic and/or academic programs, as well as past medical or psychiatric conditions.

7. The Citadel requires all cadets to be covered by **supplemental health insurance** (either a family policy or individual student policy). Information about student health insurance and other medical topics of interest is available on The Citadel website (www.citadel.edu/infirmary/).

If you have questions about medical forms, medical clearance, Infirmary services, etc., please call **(800) 868-1842, Option 6**, or **(843) 953-4827**, between 7:30 am and 4:00 pm, Monday through Friday. Our e-mail is **bpelham@citadel.edu**. Our FAX # is **(843) 953-5283**.

Medical forms may be emailed, faxed, mailed, or FedEx'd.

EMAILED TO: bpelham@citadel.edu FAXED TO: 843-953-5283
MAILED TO: The Citadel Infirmary, 171 Moultrie Street, Charleston, SC 29409
FedEx, DHS TO: The Citadel Infirmary, 9 Hammond Ave, Charleston, SC29409

Forms are due **BEFORE May 1**. Forms will not be accepted once the class is full – *even if this occurs before May 1.*

THE CITADEL
THE MILITARY COLLEGE OF SOUTH CAROLINA

For Staff Use Only

MEDICAL INFORMATION
(This page completed by applicant)

CWID _____

PLEASE PRINT: DATE (mm/dd/yy) _____/_____/_____

_____ X X X - X X - __ __ __ __

NAME: Last First Middle Social Security Number (Last four digits only)

_____

Street Address City State Zip

(____) _____ (____) _____ _____ MALE ☐ FEMALE ☐

Home Phone Work Phone Date of Birth (mm/dd/yy) Please check one

_____ _____ _____

Father's Name Mothers Name Email address

Military dependent: YES / NO If "Yes" give sponsor's SSN: X X X - X X - __ __ __ __

TRICARE Standard _____ TRICARE Prime (Charleston PCM only) _____

Religion (if you desire visitation by a chaplain of your faith when admitted to the Infirmary or hospital) _____

Medications: Do you take any medications on a regular basis? If so, please list them here:

Name	Dosage	Reason

Important Notes:

1. Cadets must be physically able to participate in the following ***physical activities:*** two mile runs, sit-ups, push-ups, running in place, crunches, leg lifts, rapidly climbing/descending three flights of stairs without using handrails, rifle manual (grasping & rapidly manipulating a 9 pound M-14 rifle with either hand), marching in formation, and a variety of other physical activities which are the equivalent of light-contact sports. Because initial cadet training is only offered once, cadets who miss more than 30% of the 4th Class Training Period (first two weeks) due to injury or illness will be referred for medical review and possible medical discharge.

2. Failure to report all ***current*** and ***previous physical & mental conditions*** will be grounds for termination of your cadet career with forfeiture of appropriate tuition and fees.

CWID _____

MEDICAL HISTORY

(This page completed by applicant)

PLEASE PRINT NAME:

_____ _____ MALE ☐ FEMALE ☐

Last **First** **M.I.** **Date of Birth** **Please check one**

Have you ever had, or do you now have, any of the following? If **"Yes"**, please explain under **"Remarks."**

Yes	No	(Check each item)	Yes	No	(Check each item)
		Dizziness, loss of consciousness, or fainting			Eating disorder (anorexia, bulimia, etc)
		High blood pressure or stroke			Eye problems or vision changes
		Hay fever or seasonal allergies			Wears glasses or contact lenses
		Reactions to medications, foods, or insect stings			Hearing loss or recent ear infections
		Surgery; or visited / advised to visit a surgeon			Visit to a rheumatologist (arthritis, lupus, etc)
		Concussions or head injuries			Frequent or persistent colds
		Frequent or severe headaches, migraines			Sinus infections / sinusitis
		Dental pain, tooth or gum problems			Mouth or nose problems
		Epilepsy, seizures, convulsions, or fits			Tooth or gum problems
		Scarlet fever, rheumatic fever			Thyroid or throat problems
		Tumor, cyst, unusual growth, or cancer			Males: problems w/ testicles, scrotum, penis
		Visit to a cardiologist / heart specialist			Females: problems w/ menses, breasts, Paps
		Chest pain or pressure, palpitations (pounding heart)			Muscle weakness, paralysis, or lameness
		Heart problems (murmur, abnormal rhythm, etc.)			Painful or swollen joints: ankle, wrist, fingers, knee, etc.
		Shortness of breath with exercise			Dislocatable or "trick" shoulder, elbow, or knee
		Asthma (reactive airways), recurrent wheezing			Bone problems (pain, pins/plates, fractures in last 5 yrs)
		Chronic cough, lung disease, or recurrent bronchitis			Back or neck pain (severe or recurrent)
		Tuberculosis (TB), or close contact with TB patient			Wears a brace or a splint
		Diabetes, blood sugar too high, or blood sugar too low			Bone or joint deformity
		Stomach, liver, or gallbladder problems / gallstones			Frequent leg cramps or persistent foot problems
		Hepatitis, jaundice, or liver problems			Attempted suicide, and/or recurrent thoughts of suicide
		Gastroesophageal reflux / GERD, irritable bowels			Clinical depression, excessive worry, or anxiety
		Intestinal disease (Crohn's disease, ulcerative colitis)			Bipolar disorder, schizophrenia, other psychosis
		Coughed up or vomited blood			ADD / ADHD, learning disability, or speech problem
		Hemorrhoids, or rectal disease			Visit to psychiatrist, psychologist, or counselor
		Black or bloody stools			Excess bleeding, easy bruising, or blood disorders
		Kidney stones, kidney infections or kidney problems			Visit to a hematologist or oncologist
		Frequent or painful urination, or blood in the urine			Skin problems (psoriasis, eczema, severe acne)
		Hernia or rupture			Other significant **illness or surgery** not listed above

** Please note that any "**Yes**" answer may require a **doctor's report** and full **medical release** to gain admission.

Explain each **"YES,"** above: _____

_____

_____

_____

_____

Student Signature: _____

CWID _____

PHYSICAL EXAMINATION

(To be completed by Physician: MD or DO)

PLEASE PRINT NAME:

_____ _____ MALE ☐ FEMALE ☐

Last **First** **M.I.** **Date of Birth** **Please check one**

Height: ____ft/____in **Weight**: _____lbs **Blood Pressure** (sitting) _____/_____ **Pulse** (sitting) _____

Distant Vision: UNCORRECTED: (Required for all) Right 20/_____ Left 20/ _____ CORRECTED: (If wearing lenses) Right 20/_____ Left 20/ _____

Physical Examination: Please describe each abnormal finding in the REMARKS section, especially those **abnormalities** affecting coordination and exercise tolerance. ***Required physical activities*** are included on Page 2, "Medical Information," above.

Normal	Abnormal		Normal	Abnormal	
		Head, face, neck, scalp			G-U (males: r/o hydrocele & varicocele)
		Eyes			Hernia
		Ears & hearing			Rectal (visual inspection only)
		Nose & sinuses			Spine (motion, flexibility, scoliosis)
		Mouth, throat, teeth, jaw			Upper extremities (shoulders, arms, forearms)
		Neck & thyroid			Lower extremities (hips, thighs, legs)
		Lungs & chest			Hands & Feet
		Heart			Neurological
		Vascular system			Skin
		Abdomen & viscera			Tattoos (please list size and location)

Physician, please describe any **abnormalities**:

_____

_____

_____

_____

_____

Note: Please ensure that ALL ITEMS, on BOTH pages of the H & P are completed before signing.

Doctor's Signature _____ **MD / DO** Date _____

Printed/Stamped Name _____ Phone (_____)_____

Office Address _____

CWID _____

THE CITADEL
THE MILITARY COLLEGE OF SOUTH CAROLINA

MEDICAL INSURANCE INFORMATION

STUDENT INFO

- Full Name _____
- Social Security Number _____
- Date of Birth _____

INSURED INFO

- Insured' s Name (Policy Holder) _____
- Insured's Date of Birth _____
- Insured's Address _____
- City _____ State _____ Zip Code _____
- Insured's Phone Home: _____ Work: _____

INSURANCE COMPANY INFO

- Insurance Company Name _____
- Ins. Co. Street Address _____
- City _____ State _____ Zip Code _____
- Ins. Co. Phone Number _____
- Insured's Policy/ID Number _____
- Group Number/Name _____
- Please attach a **PHOTOCOPY** of your **INSURANCE CARD** (both *front* & *back* sides)

In the space below please provide a copy of the front and back of the insurance card.

Front of Card

Back of Card

CWID _____

MILITARY DEPENDENTS
AND
CERTIFICATION AND CONSENT

Military Dependents

- Military dependent covered by **TRICARE**: _____Yes _____ No
- If "Yes", please provide Sponsor's SSN: X X X - X X - __ __ __ __
- Please check which coverage: ___ Tricare Standard ___ Tricare Prime (Charleston residents only)
- NOTE: Because of **recurrent problems** with PCM assignments & PCM referrals for off-campus care while at The Citadel, we urge you to switch your cadet from **TRICARE PRIME** to **TRICARE STANDARD**. Details are available from your local TRICARE Service Center, or the TRICARE website: http://www.mytricare.com.
- Please attach a PHOTOCOPY of **TRICARE CARD** (front & back) **or** applicant's **ID Card** (front & back) on page 5

Certification and Consent

- I understand that **ALL CADETS** must carry **SUPPLEMENTAL HEALTH INSURANCE** for the entire period of enrollment at The Citadel, in order to avert financial hardship due to hospital admissions, emergency department care, subspecialty care, or other medical services not available at The Citadel. I will notify the Infirmary of any changes to insurance coverage as soon as they occur.

- I further understand that my **signature**, below, grants **permission** for the Citadel Infirmary and Sports Medicine staffs to treat my son or daughter for routine medical conditions.

•Parent/Guardian Signature_____Date_____

CWID _____

THE CITADEL
THE MILITARY COLLEGE OF SOUTH CAROLINA

*****Attaching an immunization record to this form is NOT ACCEPTABLE. Please transfer all required dates to this form.**

IMMUNIZATION RECORD

REQUIRED TO BE COMPLETED BY PHYSICIAN'S OFFICE

Applicant's name _____ Date of birth _____

The following immunizations are required, recommended, or suggested for cadets enrolled at The Citadel. This form must be completed and signed by the applicant's physician. If you desire a medical or religious waiver for any required immunizations, please contact The Citadel Infirmary, 843-953-4827.

1. **Varicella:** Varicella vaccine is ***not*** required if applicant has had chickenpox (give month & year): ___/___
   Vaccination is ***required*** if you never had chickenpox: - 1st shot _____/_____/_____
   - 2nd shot _____/_____/_____
2. **Diphtheria-Tetanus-Pertussis: (Required)**
   Date completed first 3 shots (usu. by 6 months) _____/_____/_____
   Date of last booster shot (usu. age 11-12 years) _____/_____/_____
3. **Poliomyelitis: (Required)**
   Date completed first 3 shots (usu. age 6-18 months) _____/_____/_____
   Date of last booster (usu. age 4-6 years) _____/_____/_____
4. **Measles-Mumps-Rubella** (MMR): **(Required)**
   Date of 1st shot (usu. age 12-15 months) _____/_____/_____
   Date of 2nd shot (usu. age 4-6 years) _____/_____/_____
5. **Hepatitis B: (Required)**
   Date of 1st shot (usu. at birth) _____/_____/_____
   Date of 2nd shot (usu. age 1-2 months) _____/_____/_____
   Date of 3rd shot (usu. age 6-18 months) _____/_____/_____
6. **Tuberculin Test (PPD): (Recommended** for applicants at risk for TB exposure***)**
   * Living in Africa, S. America, Central America, or Asia; or has family member infected with TB
   DATE _____/_____/_____ NEGATIVE____ POSITIVE ____ (if Positive, give mm: _____)
   CHEST X-RAY (if Positive) _____
   Treatment (if any) _____
7. **Meningococcal** Vaccine (**Recommended** for incoming knobs) _____/_____/_____
   * For more information, refer to http://www.citadel.edu/infirmary/annoucements-a-health-updates.html
8. **Sickle Cell** screen (**Suggested** for **NCAA Div I Athletes** only): Neg __ Pos ___ (Disease? Trait?)
   * For more information, refer to http://www.citadel.edu/infirmary/annoucements-a-health-updates.html

*****Attaching an immunization record to this form is NOT ACCEPTABLE. Please transfer all required dates to this form.**

_____
Physician's Signature

_____
Printed/Stamped Name

_____
City, State, Zip

_____ (_____)_____
Date Area Code and Phone Number