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, SC 29409
MEDICAL INFORMATION
(This page completed by applicant)

CWID: __________________________

PLEASE PRINT: ____________________

DATE (mm/dd/yy) ___/___/____

NAME: Last First Middle

X X X - X X - ___ ___ ___ ___

Social Security Number (Last four digits only)

Street Address: ____________________

City: ____________________

State: ________ Zip: ________

(   ) (     ) ___ Home Phone: ________

Work Phone: ________ Date of Birth (mm/dd/yy): _____________________

Please check one MALE □ FEMALE □

__________________________________________

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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.

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

For Staff Use Only
**MEDICAL HISTORY**
(This page completed by applicant)

Please print name:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
<th>Date of Birth</th>
<th>Please check one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MALE ☐</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>FEMALE ☐</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>(Check each item)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dizziness, loss of consciousness, or fainting</td>
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<td></td>
<td></td>
<td>High blood pressure or stroke</td>
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<tr>
<td></td>
<td></td>
<td>Hay fever or seasonal allergies</td>
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<td></td>
<td></td>
<td>Reactions to medications, foods, or insect stings</td>
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<td></td>
<td></td>
<td>Surgery; or visited / advised to visit a surgeon</td>
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<tr>
<td></td>
<td></td>
<td>Concussions or head injuries</td>
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<tr>
<td></td>
<td></td>
<td>Frequent or severe headaches, migraines</td>
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<td></td>
<td></td>
<td>Dental pain, tooth or gum problems</td>
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<td></td>
<td></td>
<td>Epilepsy, seizures, convulsions, or fits</td>
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<td></td>
<td></td>
<td>Scarlet fever, rheumatic fever</td>
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<td></td>
<td></td>
<td>Tumor, cyst, unusual growth, or cancer</td>
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<td></td>
<td></td>
<td>Visit to a cardiologist / heart specialist</td>
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<tr>
<td></td>
<td></td>
<td>Chest pain or pressure, palpitations (pounding heart)</td>
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<tr>
<td></td>
<td></td>
<td>Heart problems (murmur, abnormal rhythm, etc.)</td>
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<tr>
<td></td>
<td></td>
<td>Shortness of breath with exercise</td>
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<tr>
<td></td>
<td></td>
<td>Asthma (reactive airways), recurrent wheezing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chronic cough, lung disease, or recurrent bronchitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tuberculosis (TB), or close contact with TB patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes, blood sugar too high, or blood sugar too low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stomach, liver, or gallbladder problems / gallstones</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatitis, jaundice, or liver problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastroesophageal reflux / GERD, irritable bowels</td>
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<tr>
<td></td>
<td></td>
<td>Intestinal disease (Crohn’s disease, ulcerative colitis)</td>
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<tr>
<td></td>
<td></td>
<td>Coughed up or vomited blood</td>
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<tr>
<td></td>
<td></td>
<td>Hemorrhoids, or rectal disease</td>
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<tr>
<td></td>
<td></td>
<td>Black or bloody stools</td>
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<tr>
<td></td>
<td></td>
<td>Kidney stones, kidney infections or kidney problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequent or painful urination, or blood in the urine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hernia or rupture</td>
</tr>
</tbody>
</table>

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

Explain each "YES," above:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Wears a brace or a splint

Bone problems (pain, pins/plates, fractures in last 5 yrs)

Bone or joint deformity

Frequent leg cramps or persistent foot problems

Attempted suicide, and/or recurrent thoughts of suicide

Clinical depression, excessive worry, or anxiety

Bipolar disorder, schizophrenia, other psychosis

ADD / ADHD, learning disability, or speech problem

Visit to psychiatrist, psychologist, or counselor

Excess bleeding, easy bruising, or blood disorders

Visit to a hematologist or oncologist

Skin problems (psoriasis, eczema, severe acne)

Other significant illness or surgery not listed above

Student Signature: ____________________________________________
**PHYSICAL EXAMINATION**  
(To be completed by Physician: MD or DO)

**PLEASE PRINT NAME:**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
<th>Date of Birth</th>
<th>MALE □ FEMALE □</th>
</tr>
</thead>
</table>

**Height:**  ____ft/____in  **Weight:**  ____lbs  **Blood Pressure** (sitting)  _____/______  **Pulse** (sitting)  ____

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

**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.

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

**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** ___________________________  
**Phone** (______) ______________________  
**Office Address** ____________________________________________
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
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 __________________
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/announcements-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/announcements-a-health-updates.html

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