MUSC Health
Medical University of South Carolina
at
THE CITADEL

Student Health Services
Phone: 843-953-4827
Email: citadel@musc.edu

Patient Demographic Information

CWID:_____

Last Name:	First Name:	Middle Initial:
Date of Birth:	SSN:	Marital Status:
Home Address:		
Home Phone:	Cell Phone:	Email:
Parent/Guardian:		Cell Number:
Preferred Gender:		Language:
Are you a veteran: Yes / No	Ethnicity Other:	Hispanic or Latino / Not Hispanic or Latino
Race (please circle one): American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander White or Caucasian / Refuse		

Patient Insurance Information

Insurance Company Information		
Insurance Company Name:	Insurance Company Claims Address (back of card):	
Insurance Company Phone Number:	Policy/ID Number and Issue Date:	Group Number:
Subscriber (Policy Holder) Information		
Subscriber Name (first & last):	Cell Phone:	Email:
Subscriber Date of Birth:	Subscriber Gender	Service Member SSN (TriCare Only)
Copies of the front and back of the insurance card are required- please sent with the completed packet		

Front of Insurance Card

Back of Insurance Card

AUTHRELSE

MUSC Health at The Citadel
Authorization to Disclose Protected Health Information

Form Origination Date: 6/2022
Version: 1 Version Date: (6/2022)

CWID:_____

Patient Name _____

MRN_____

PATIENT IDENTIFICATION LABEL

Patient Name: _____
(print legal name of patient/Citadel applicant)

All healthcare information is private. MUSC will share the above patient/student's protected health information with The Military College Infirmary a/k/a The Citadel Infirmary as necessary for continuum of care of the patient.

By signing this authorization form, the above-named patient/student, authorizes MUSC to share and disclose a limited subset of protected health information, with The Military College a/k/a The Citadel. Disclosure is authorized for the purpose of allowing The Citadel, during the student's enrollment, to take appropriate actions where medically indicated and or provide medically necessary leaves, accommodations, restrictions and or modifications to school related activities as necessary for the wellbeing of their students. The purpose of this authorization, is to allow The Citadel, during the student's enrollment, to facilitate or provide medically necessary leaves, accommodations, restrictions and or modifications to school related activities.

Examples of protected health information that may be shared, include but are not limited to: dates and times when the patient/student was seen at MUSC, recommendations for quarantine, contact tracing, bed rest, medical leave, recommendations and/or restrictions related to uniform compliance and/or involvement in activities and or cadet duties.

MUSC will share protected health information with The Citadel using a minimum necessary standard.

I understand that this information may be exchanged by mail, fax, email, phone, or a secure web-based software.

I understand that I have a right to cancel this permission at any time. I understand that if I cancel this permission I must do so in writing and present my written cancellation to the MUSC at The Citadel clinic. I understand that the cancellation will not apply to information that has already been released in response to this permission, as stated in the Notice of Privacy Practice. I understand this consent form is valid until I revoke it or am no longer enrolled at the Citadel.

I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information disclosed, as provided in 45 CFR 164.524.

I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. Upon request, I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 18 years or older.

_____ _____
Signature of Patient or Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____ _____ _____
Witness Printed Name Witness Signature Date

_____ _____
Printed Name Patient or Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____
Relationship to Patient

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VACCINATION RECORDS

CWID:_____

Mandatory Vaccinations

ANTIBODY TITER	**MONTH / DAY / YEAR**	**TITER RESULTS :**			
Measles / Rubeola IgG		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
Mumps IgG		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
Rubella IgG		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
MMR VACCINES	**MONTH / DAY / YEAR**	**Verifying Documentation Attached**			
#1 Measles---Mumps---Rubella					
#2 Measles---Mumps---Rubella					
ANTIBODY TITER	**MONTH / DAY / YEAR**	**TITER RESULTS: Negative / Equivocal / Borderline / Indeterminate Titer requires vaccination.**			
Varicella IgG Titer:		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
VARICELLA VACCINES	**MONTH / DAY / YEAR**	**Verifying Documentation Attached**			
#1 Varivax					
#2 Varivax					
TETANUS VACCINES	**MONTH / DAY / YEAR**	**Verifying Documentation Attached**			
Tetanus/Diphtheria/Pertussis (Tdap)					
Tetanus/Diphtheria (Td)					
Meningitis Vaccine Proof of Vaccination after age 16 OR Signed Waiver	**MONTH / DAY / YEAR**	☐ Menactra ☐ Menveo ☐Menomune ☐ Unknown **(Attach Documentation of Vaccination)** ☐ I do not wish to receive the meningococcal vaccine. I have read the information and completed the on-line form at https://lifenet.musc.edu			

Recommended Vaccinations

Primary Hepatitis B Vaccine Series	**Dose #1** ___/___/___ MONTH/ DAY / YEAR	**Dose #2** ___/___/___ MONTH/ DAY / YEAR	**Dose #3** ___/___/___ MONTH/ DAY / YEAR	☐ **Attach documentation of vaccination**
	Hepatitis B Surface IgG Antibody Titer Date_____	☐ **Immune Titer**	**Non – Immune Titer** ☐ Equivocal/ Borderline ☐ Negative	☐ **Lab Report Attached**
		_____mIU/mL Titer Result	Equivocal or Negative Titers – see Page 1	

	Dose #4	**Dose #5**	**Dose #6**	
Secondary Hepatitis B Vaccine Series (If Non-Immune After Primary Series)	___/___/___ MONTH/ DAY / YEAR	___/___/___ MONTH/ DAY / YEAR	___/___/___ MONTH/ DAY / YEAR	☐ **Attach documentation of vaccination**
	Hepatitis B Surface IgG Antibody Titer Date_____	☐ **Immune Titer**	**Non – Immune Titer** ☐ Equivocal/ Borderline ☐ Negative	☐ **Lab Report Attached**
		_____mIU/mL Titer Result	Equivocal or Negative Titers – see Page 1	

Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	**Date:**	Hepatitis B Surface Antigen (If 2nd titer is negative)	**(Attach Lab Report)**
	Date:	Hepatitis B Core Antibody (If 2nd titer is negative)	**(Attach Lab Report)**
Chronic Active Hepatitis B	**Date:**	Hepatitis B Surface Antigen	**(Attach Lab Reports)**
	Date:	Hepatitis B Viral Load (PCR)	

Covid-19 Vaccine	**Dose #1** ___/___/___ MONTH/ DAY / YEAR (circle one) Pfizer Moderna J&J	**Dose #2** ___/___/___ MONTH/ DAY / YEAR (circle one) Pfizer Moderna J&J	**Dose #3** ___/___/___ MONTH/ DAY / YEAR (circle one) Pfizer Moderna J&J

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The following pages need to be completed with and signed by a licensed primary care Physician or Advanced Practice Provider who is not related to you.

If your child is a new student-athlete (including those who plan to try-out for a team) please request a **sickle cell solubility test** from your physician. As of August 1, 2022 the NCAA requires screening for sickle cell trait/disease for all student-athletes in their initial season of eligibility. This option is no longer available for opt-out through waiver per the organization for safe collegiate competition. Please forward test results with the remainder of the documentation in this packet.

Additional information for the NCAA requirements is available through their website: www.ncaa.org.

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History Form

CWID:_____

Note: Complete and sign this form (with your parents if younger than 18) and bring the completed document to your physical examination.

Name: _____ Date of birth: _____

Sex assigned at birth (M, F, Intersex): _____ How do identify your gender?: _____

List past and current medical conditions:

_____

_____

_____

Have you ever had surgery? If yes, list all past surgical procedures:

_____

_____

_____

Medicines and supplements – List all prescriptions, over-the-counter medicines, and supplements (herbal and nutritional):

_____

_____

_____

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollens, food, stinging insects):

_____

_____

Please submit all food allergies and dietary restrictions through https://go.citadel.edu/matriculationhq/ in addition to this form.

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical issues or recent illness?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
7. Has a doctor ever told you that you have any heart problems?	☐	☐
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly- morphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

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History Form

CWID:_____

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	☐	☐
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐
22. Have you ever become ill while exercising in the heat?	☐	☐
23. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
24. Have you ever had or do you have any problems with your eyes or vision?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
28. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain all "Yes" answers here.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Physical Examination Form

CWID:_____

Name: _____ Date of Birth: _____

BODY MEASUREMENTS Please Note: Three separate measurements are required. Average the three to the nearest				
	First	**Second**	**Third**	**Average**
Male/Female - Measure neck just below level of larynx and round up to the nearest 0.50 inch.				
Male Only - Measure abdomen at the level of the navel (belly button) and round down to the nearest 0.50 inch.				
Female Only – Measure abdomen at the point of minimal abdominal circumference and round down to the nearest 0.50 inch.				
Females Only – Measure hips at point where the gluteus muscles (buttocks) protrude backward the most and round down to the nearest 0.50 inch.				

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: □ Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart (Consider ECG, echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.) • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), ortinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

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Medical Eligibility Form

CWID:_____

Name: _____ Date of Birth: _____

Health care professional to read the following section in full before signing

I have examined the patient named on this form and completed a review of the patient's provided medical history and pre-participation physical evaluation. I have found no apparent clinical contraindications for the patient to participate in rigorous activity and undergo psychological stressors including but not exclusive to those listed below which are part of the military and physical training components at The Citadel.

The applicant exhibits sufficient visual, auditory, communicative, motor, strength, dexterity, mobility, and cardiopulmonary capacities to perform the following actions:

- Bracing (holding a rigid upright position, shoulders drawn, scapula retracted, arms at side, and chin retracted) for extended periods
- Periods of prolonged (up to 50 minutes)standing at attention/bracing/walking/marching with rifle in severe heat and high humidity conditions
- Driving (running) four flights of stairs multiple times per day
- Running 1-2 miles during early morning 5:30AM regimental physical training multiple times per week
- Performing high impact interval training (upper and lower body) for up to 50 minutes in severe heat and high humidity conditions: push-up, pull-ups, kettle bell and medicine ball workouts
- Participate in basic combative training involving striking techniques, boxing, and grappling (personal protective equipment provided)
- Tactical training: low crawling, log carries, tire flips, buddy carries, ammo can lifts, etc
- Completing a United States Marine Corps obstacle course: running, rope climbing, balance beam walking, wall scaling
- Ability to achieve and maintain specified weight and body fat measurements based on the United States Army standard
- Citadel Physical Fitness Test: male minimum(10 hand release push-ups, 1:10 minute plank, 12:45 minute 1.5 mile run), female minimum(10 hand release push-ups, 1:10 minute plank, 15:00 minute 1.5 mile run)

The applicant also demonstrates appropriate insight and capacity to understand upon entrance to The Citadel they will be subjected to significant lifestyle changes which may result in heightened emotional and psychological stress including:

- Periods of high stress applied from an adversarial 4th class system receiving instruction and learning from cadre and upperclassmen in a direct intense manner.
- A week-long period without contact of family or friends while experiencing emotional, mental, and physical stress
- Being held to high standards of professional appearance, personal conduct, and institutional discipline with consequences for deviation from prescribed standards.
- Reduced sleep and limited free to time due to a regimented schedule with early morning physical training, long academic days, and military duties.
- Limited permissive leave to go off campus during the week or weekends

Name of health care professional (print or type)_____ Date:_____

Address: _____ Phone:_____

Signature of health care professional:_____ DO, MD, NP or PA