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
MEDICAL INFORMATION
(This page completed by applicant)

PLEASE PRINT:

DATE (mm/dd/yy) _____/_____/_____

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
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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.
**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: ________________________________________________
PHYSICAL EXAMINATION
(To be completed by Physician: MD or DO)

PLEASE PRINT NAME:

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

MALE ☐  FEMALE ☐

Height:  ____ft/____in  Weight:  _____ lbs  Blood Pressure (sitting) ____/_____  Pulse (sitting) _____

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

<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** ________________

Printed/Stamped Name ____________________________________________  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 _____/_____/_____
   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.***

Physician’s Signature

Printed/Stamped Name

City, State, Zip

Area Code and Phone Number

Date

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