ARMY CADETS OF AMERICA	REPORT OF MEDICAL EXAM	FOR OFFICIAL USE ONLY

INSTRUCTIONS

Acceptance criteria for applicants the Army Cadets of America (ACA) are listed on the reverse side. No one will be denied admission to the program due to a medical disability, however participation may be limited if the cadet is not able to meet the medical standards necessary to FULLY participate in **training activities involving strenuous physical exercise and activities such as long marches, running, and training in hot and humid environments.** The examiner should list any condition(s) that could interfere with full, unrestricted, participation in the Army Cadets of America. Conditions that will or are likely to require treatment particularly unresolved injuries and recurrent illness must be listed. The history of immunization should be verified to the satisfaction of the medical examiner. A licensed medical provider must complete this examination.

1. UNIT INFORMATION

1a. Unit Name	**1b.** UIC

2. PERSONNEL INFORMATION

2a. Last Name	**2b.** First Name	**2c.** MI	**2d.** Social Security Number

2e. Age	**2f.** Date of Birth (DD MMM YY)	**2g.** Sex ☐ Male ☐ Female	**2h.** Parent/Guardian Name (cadets only)

2i. Home Address	**2j.** City	**2k.** State	**2l.** Zip Code + 4

2m. Home Phone	**2n.** Date of Physical Examination (DD MMM YY)	**2o.** Location of Physical Examination

4. CLINICAL EVALUATION

Anatomy	**Normal**	**Abnormal**	**NOTES:** (Describe every abnormality in detail. Enter pertinent item number before each **comment)**
4a. Head, Face, Neck, and Scalp	☐	☐	
4b. Nose	☐	☐	
4c. Sinuses	☐	☐	
4d. Ears – General *(Internal and External Canals)*	☐	☐	
4e. Drum *(Perforation)*	☐	☐	
4f. Eyes- General	☐	☐	
4g. Ophthalmoscopic	☐	☐	
4h. Pupils *(Equality and Reaction)*	☐	☐	
4i. Heart *(Thrust, Size, Rhythm, and Sounds)*	☐	☐	
4j. Lungs and Chest	☐	☐	
4k. Abdomen and Viscera *(Include Hernia)*	☐	☐	
4l. External Genitalia *(Genitourinary)*	☐	☐	
4m. Upper Extremities	☐	☐	
4n. Lower Extremities	☐	☐	
4o. Feet	☐	☐	
4p. Spine and other Musculoskeletal	☐	☐	

5. LABORATORY FINDINGS *(only required for those with a history of urinary tract infections or anemia, enter N/A if tests were not administered)*

5a. Urinalysis		**5b.** Blood	
(1) Albumin:	**(2)** Sugar:	**(1)** Hemoglobin:	**(2)** Hematocrit:

6. MEASUREMENTS AND OTHER FINDINGS

6a. Height	**6b.** Weight	**6c.** Obese	**6d.** Pulse	**6e.** Blood Pressure	
inches	lbs.	☐ Yes ☐ No		**(1)** Systolic:	**(2)** Diastolic:

6f. Audiogram (if available)

HZ	**500**	**1000**	**2000**	**3000**	**4000**	**6000**
Right						
Left						

6g. Wears Glasses	**6h.** Wears Contacts	**6i.** Uncorrected Vision	
☐ Yes ☐ No	☐ Yes ☐ No	**(1)** Left: 20/	**(2)** Right: 20/

6k. Color Vision

6l. Other Findings (if more room is needed, continue on reverse)

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7. CLINICAL SCREENING (Please check if the patient has any of the following conditions and whether it will affect the ability to participate in Army Cadets of America activities.)

Condition(s)	**Pre-Existing**	**NOTES:** (Describe every condition in detail. Enter pertinent item number before each **comment)**
7a. Seizure or convulsion disorder	☐ Yes ☐ No	
7b. Asthma	☐ Yes ☐ No	
7c. Symptomatic/recurring orthopedic injury	☐ Yes ☐ No	
7d. Diabetes, Type I	☐ Yes ☐ No	
7e. Diabetes, Type II	☐ Yes ☐ No	
7f. Hypersensitivity to Food	☐ Yes ☐ No	
7g. Insect bites/stings sensitivity	☐ Yes ☐ No	
7h. Head injuries resulting in residual impairment	☐ Yes ☐ No	
7i. Neurological Impairment	☐ Yes ☐ No	
7j. History of recurring loss of consciousness	☐ Yes ☐ No	
7k. History of debilitating motion sickness	☐ Yes ☐ No	
7l. Sleepwalking	☐ Yes ☐ No	
7m. Bedwetting	☐ Yes ☐ No	

8. NOTES, REMARKS, AND OTHER FINDINGS (Use additional sheets of paper if needed)

9. MEDICAL PROVIDER ENDORSEMENT (Check all that apply):

I have reviewed the data above, reviewed the patient's medical history form and make the following recommendations for his/her participation in the Army Cadets of America

9a. ☐ **CLEARED WITHOUT RESTRICTIONS**

9b. ☐ Cleared **AFTER** further evaluation or treatment for:

9c. ☐ Cleared for **LIMITED** participation

- ☐ Not cleared for (specify activities):
- ☐ Cleared only for (specify activities):

Reasons:

9d. ☐ **NOT CLEARED FOR PARTICIPATION**

Reasons:

9e. ☐ **OTHER RECOMMENDATIONS**

- ☐ Recommend close monitoring during conditioning because of weight/fitness/other.
- ☐ Recommend restrictions or monitoring of weight loss/gain or fitness concerns.
- ☐ Recommend participations under following condition(s):
- ☐ Other:

10. MEDICAL PROVIDER

10a. Name of Medical Provider (Type or Print) or Medical Provider Stamp	**10b.** Signature (MD, DO, PN, PA)	**10c.** Date (DD MMM YY)

10b. Medical Provider Address	**10c.** City	**10c.** State	**10c.** Zip Code +4	**10c.** Phone