



# Marine Military Academy

## MEDICAL ADDENDUM

(Parent/Guardian must complete)

Name of Cadet (or Applicant): \_\_\_\_\_  
Please Print Last First Middle

1. During the past 12 months (since his last doctor physical) has your son: YES NO  
a. been hospitalized?  
b. had an injury requiring a doctor's visit?  
c. had an illness lasting more than one week?  
If yes to any of the above questions, please provide date(s) and reason(s): \_\_\_\_\_

2. Does your son take any medication(s) regularly?  
If yes, please list medication with corresponding diagnosis: \_\_\_\_\_

3. Is there a reason limits should be put on your son's participation in sports?  
If yes, please explain reason(s): \_\_\_\_\_

4. I affirm my child can swim or is not at risk of injury or death when swimming or otherwise accessing a body of water:

5. Do you prohibit your son from participation in contact sports such as football and/or boxing?  
If yes, please explain reason(s): \_\_\_\_\_

6. Has your son had a concussion, fracture or been knocked out?  
If yes, please explain reason(s) and date(s) of injury: \_\_\_\_\_

7. Has your son had convulsions, seizures, or been diagnosed with Epilepsy?  
If yes, please explain reason(s) and date(s) of occurrence: \_\_\_\_\_

8. Is your son currently undergoing or has he undergone psychiatric care?  
If yes, please explain reason **and include** a letter along with three office notes from the psychiatrist/doctor: \_\_\_\_\_

9. Is your son missing any organs?  
If yes, please explain: \_\_\_\_\_

10. Is your son wearing a dental appliance? (i.e. braces, retainer, etc.)

11. Has your son been treated for a back or neck injury?  
If yes, please explain reason(s) and date(s) injury: \_\_\_\_\_

12. Is your son allergic to any medication(s)?  
If yes, please list medication(s) with allergic reaction symptom(s): \_\_\_\_\_

13. Does your son have any condition or undergoing medical treatment not otherwise indicated?  
If yes, please explain: \_\_\_\_\_

14. My son received a TB skin test on \_\_\_\_\_ (date) result was negative on \_\_\_\_\_ (date).  
*The primary purpose of a TB screening is to maintain a healthy and safe campus environment and to reduce the direct and indirect costs associated with a case of tuberculosis disease on campus.*

15. Parent/Guardian permission required for son to receive the influenza vaccine at a cost of \$25.00 billable to the parent/guardian. YES NO Not Applicable: vaccine given: \_\_\_\_\_ (date).  
*The Influenza vaccine will be given between October and November each year. It is NOT a required vaccine.*

16. Has your son received immunizations not otherwise indicated or recorded by the MMA Medical Dept? Please provide an updated copy if your answer is yes.

I certify all information contained above is true, complete, and correct.

Date: \_\_\_\_\_ Parent/Guardian Signature Authorization: \_\_\_\_\_