MASSANUTTEN

MILITARY ACADEMY

Medical Evaluation and Immunization Records

MMA Health Services – Infirmary

540-459-0425 Fax: 540-459-7642

To Be Completed by **Physician**

Cadet's Name:____ Birth date: ____/___ /____

Last name First Middle (initial)

Allergies:____

Type of Reaction:____

Sex: _____ Height: _______ Weight: ________ Blood Pressure: ________

*Please indicate any **abnormalities** of the following systems. Describe/explain fully, as appropriate, on the reverse side of this form.*

	Yes	No
General Appearance		
Skin		
Head		
Eyes		
Ears		
Nose		
Throat		
Mouth/Teeth		

	Yes	No
Cardiovascular		
Hernia/Tanner Stage		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Respiratory		
Gastrointestinal		
Genitourinary		

	Yes	No
Ankles		
Knees		
Feet		
Back		
Shoulders		
Neck		
Chest		
Other		

Is this cadet (student) physically fit for participation in competitive sports and military programs? ___ Yes ___ No

If no, please specify why not:

REQUIRED IMMUNIZATIONS – Please indicate the month, day, and year on which vaccine doses were given.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTP/DTaP (4 doses minimum)					
Tdap (for 7th grade enrollment)					
Poliomyelitis (4 doses minimum with 1 dose after 4th birthday)					
MMR (2 doses minimum with 1 dose after 4th birthday)					
Hepatitis A (2 doses minimum)					
Hepatitis B (3 doses minimum)					
Varicella (2 doses)					
Meningococcal Vaccine **(**2 doses minimum for children under 16 years old or 1 dose over 16 years old)					
HPV Vaccine (2 doses for children entering 7th grade) Parent may elect for the child not to receive the HPV vaccine. **Doctor needs to indicate if parent elected not to vaccinate.**					
PPD (*if required per TB infection risk*)	Date Planted:		Date Read:		Result:

PRESCRIBED CURRENT MEDICATIONS

Medication	Dosage	Schedule Time Taken During the Day/Evening	Frequency per Day

MEDICATIONS TAKEN OVER PAST FIVE YEARS

Medication	Dosage	Schedule Time Taken During the Day/Evening	Frequency per Day

Physician's Statement

I have completed this medical evaluation. Further, as the physician prescribing the medications listed above, I hereby authorize the Academy's Infirmary staff to dispense medications as I have prescribed and as permitted by the cadet's parent/guardian(s). I acknowledge that ***changes in medications or dosages require my written confirmation to the Infirmary staff.***

____

Physician's Signature **Physician's phone #** **Date of Examination**

____

Physician's Name, printed

____

____

Contact information