Instructions for providing the required cadet physical and immunization forms.

October 2011

All Incoming Cadets and Parents

All incoming resident students (cadets) for the Milledgeville campus are required to provide proof of medical readiness prior to their enrolling into GMC as a member of the Corps of Cadets. This is required due to the strenuous nature of the activities the members of the Corps of Cadets participate in, to include daily physical training, Army ROTC training and other cadet physical activities. If you have any questions about this information, contact the GMC Student Health Services Clinic at 478-387-4839.

Physical Documentation

The various cadet programs at GMC have different requirements for documenting a cadet’s physical readiness. Depending on the cadet program you are entering, you should submit the following documentation:

If you are a cadet participating in the Early Commissioning Program (ECP), State Service Scholarship Program or the Basic Cadet Program and have a completed Military Entrance Processing Station (MEPS) physical that is less than two-years old, you should provide a complete copy of the following forms: DD Form 2707-1, (Report of Medical History), DD Form 2808 (Report of Medical Examination) to the GMC Office of Admissions.

If you are a cadet participating in the Early Commissioning Program (ECP) and have a Department of Defense Medical Evaluation Review Board (DODMERB) physical less than two years old, you should ensure that those forms have been submitted to the GMC Office of Admissions.

If you have been selected to participate in the U.S. Coast Guard Academy Preparatory Program, you should submit your Department of Defense Medical Evaluation Review Board (DODMERB) you should ensure that those forms have been submitted to the GMC Office of Admissions.

If you are a cadet participating the Basic Cadet Program and do not have a MEPS physical, you must complete the GMC Cadet Physical Examination Form, the GMC Medical History Form and a signed DA Form 3425-R Medical Fitness Statement for Senior ROTC signed by a healthcare professional, to the GMC Office of Admissions. These forms are available on the GMC website at the Health Services link under the Student Life section.

Immunization Forms: (These forms are also available on the GMC website at the Health Services link under the Student Life section)

NOTE: You should ensure that you have completed all of the required immunizations prior to enrolling at GMC as a cadet.

All incoming cadets, regardless of the cadet program they are entering, must submit the following forms to GMC prior to their enrollment: These forms must be submitted to the GMC Office of Admissions

Certificate of Immunization Form: The form must be signed by a healthcare provider. If you have previous immunization records, you should have that information transcribed onto the Cadet Immunization Requirements Form by a healthcare provider.

Meningitis Vaccine Waiver Form: This form is to verify that the cadet HAS received a vaccination against meningococcal disease or has reviewed the information provided and declined to be vaccinated.

Tuberculosis Screening. The GMC Student Health Services office will conduct a Tuberculosis screening once students/cadets arrive on campus.
# GMC Cadet Physical

## Medical History Form

<table>
<thead>
<tr>
<th>Date of Exam ___________________________</th>
<th>SS#- ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name __________________________________</td>
<td>Sex ___________________________</td>
</tr>
<tr>
<td>Grade- Freshman / Sophomore ___________</td>
<td>Sport __________________________</td>
</tr>
<tr>
<td>Home Address __________________________</td>
<td>Phone __________________________</td>
</tr>
</tbody>
</table>

### Insurance Information:
- Company Name __________________________
- Policy# __________________________
- Group# __________________________

**In case of emergency, contact:**
- Name __________________________
- Relationship __________________________
- Phone (H) __________________________
- Phone (Cell) __________________________

---

<table>
<thead>
<tr>
<th>Question</th>
<th>YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does a doctor ever denied or restricted your participation in sports for any reason?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>2. Do you have an ongoing medical condition? (diabetes, asthma or seizure disorder)?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>4. Do you have allergies to medicines, foods, or stinging insects?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>5. Have you ever passed out DURING/AFTER exercise?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>6. Do you know your Sickle Cell Status?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>7. Does anyone in your family have Sickle Cell Anemia?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>8. Have you ever had unusual pain in your chest or shortness of breath during exercise?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (example: ECG, echocardiogram)</td>
<td>YES / NO</td>
</tr>
<tr>
<td>10. Does anyone in your family have a serious heart condition?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>11. Have you ever had surgery?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>12. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, a brace, a cast, or crutches?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>13. Have you ever had a stress fracture?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>14. Do you regularly use a brace or assistive device?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>15. Has a doctor ever told you that you have asthma?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>16. Have you or anyone in your family ever been diagnosed with Marfans’ Syndrome?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>17. How many periods have you had in the last 12 months?</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

**Females Only**
- 16. Have you ever had a menstrual period stop due to extended exercise? | YES / NO |
- 17. How many periods have you had in the last 12 months? | YES / NO |

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**Explain fully, all “YES” answers**

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and accurate.

Signature of Cadet/Athlete __________________________ Date __________________________
# GMC Cadet Physical
## PHYSICAL EXAMINATION FORM

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>FINDINGS</th>
<th>INITIALS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MUSCULOSKELETAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow/forearm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/thigh</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle/Foot</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL CLEARANCE

**Is Not** Cleared for Athletic participation/Military Drill/ROTC Physical Training secondary to ____________________________________________________________

**Is Cleared** without restriction for Athletic participation/Military Drill/ROTC Physical Training ____________________________________________________________

Cleared with recommendations for further evaluation or treatment for ____________________________________________________________

Name of physician (print) ________________________________________ Date of Exam __________________________

Signature of physician ________________________________________, MD or DO. Phone __________________________

Name _____________________________________ Date of Birth _____________________ SS# _______________________

Date of Exam _______________________

Height _______ Weight _______ Body Fat % _______ HR _______ BP _______/____ (____/____, ____/____)

Vision R _______ L _______ Corrected – Yes/No Contacts/Glasses
Georgia Military College Student Health Services
201 E. Greene Street  Milledgeville GA 31061-3398
Phone: (478) 387-4839  Fax: (478) 445-1928

Cadet Immunization Requirements

Term/Year of Enrollment:  ☐ Fall  ☐ Winter  ☐ Spring  ☐ Summer  Year: 20____

Name: __________________________________________________________________________
                        Last                                                 First                                         Middle

Date of Birth: ______________________

Required Vaccines

MMR (Measles/Mumps/Rubella): #1____________________   #2____________________
   or laboratory evidence of immunity  Date _____________ Result _______________

Td or Tdap (Tetanus booster within past 10 years): ______________________

Varicella (Chickenpox): #1____________________   #2____________________
   or history of disease Date _______________
   or laboratory evidence of immunity Date _______________ Result _______________

Hepatitis B: #1____________________   #2____________________   #3____________________
   (Required for students who are age 18 years or younger at time of admission)
   or laboratory evidence of immunity Date _____________ Result _______________

Meningococcal (Meningitis): ______________________ or signed waiver attached

CERTIFICATION OF HEALTH CARE PROVIDER

Signature:____________________________________

Name: ____________________________________  Phone: ____________________________________

Address: _____________________________________________________________________________
Important Information re: Meningococcal Disease

The following information is provided to you as required by law. Please sign the attached form and return as directed.

Meningococcal Disease Facts:

☐ Meningococcal disease is a serious infection caused by bacteria, most commonly causing meningitis (an infection of the membranes that surround the spinal cord and brain) or sepsis (an infection of blood that affects many organ systems).

☐ College freshmen, particularly those living in dorms, have a modestly increased risk of getting the disease compared with other persons of the same age. Up to 100 cases occur among the 15 million college students in the United States each year, with 5-15 deaths. However, the overall risk of disease, even among college students, is low.

☐ Crowded living conditions and smoking (active or passive) are additional risk factors that are potentially modifiable.

☐ Bacteria are spread from person-to-person through secretions from the mouth and nose, transmitted through close contact. Casual contact or breathing in the same air space is not considered sufficient for transmission.

☐ Common symptoms include: stiff neck, headache, fever, sensitivity to light, sleepiness, confusion, and seizures. Invasive meningococcal disease, or blood infection with the organism, causes fever and rash.

☐ The disease can be treated with antibiotics, but treatment must be started early. Even with treatment, some patients may die. Survivors may be left with a severe disability such as the loss of a limb.

☐ A meningococcal polysaccharide vaccine is available for those who wish to pay for it.

☐ Vaccine protects against 4 of the 5 most common types of meningococcal bacteria and protection typically lasts 3-5 years.

☐ Vaccination may decrease the risk of meningococcal disease; however, it does not eliminate the risk because the vaccine does not protect against all types of meningococcal bacteria. Approximately 50-70% of disease among college students is likely to be vaccine-preventable.

☐ Vaccine may be available at travel clinics, health departments, student health services, or through private providers. Prices may vary.

☐ Information about meningococcal disease:
  ☐ the availability of a safe and effective vaccine
    http://www.cdc.gov/nip/publications/VIS/vis-mening.pdf,
  ☐ a listing of additional sources of information
    http://www.cdc.gov/nip/recs/teen-schedule.htm#chart
Meningitis Vaccine Waiver

The attached information re: meningococcal disease is provided to you as required by law.

The Georgia General Assembly passed legislation requiring public and nonpublic postsecondary educational institutions to give students residing in campus housing information about meningococcal disease and vaccine. Students are required to sign a document provided by the postsecondary institution stating that they have received a vaccination against meningococcal disease or reviewed the information and declined to be vaccinated. The governor signed the legislation on May 28, 2003; effective January 1, 2004 (Official Code of Georgia Annotated § 31-12-3.2).

Name: __________________________________________________________

Date of Birth: __________________________

Term/Year of Enrollment:  ☐ Fall  ☐ Winter  ☐ Spring  ☐ Summer  Year 20___

In keeping with the law I acknowledge I have reviewed the information provided to me by the institution and declined to be vaccinated.

________________________________________
(Date) (Signature)

________________________________________
(Date) (Parent or Guardian Signature if student is under 18)

Rev. 1/10
GEORGIA MILITARY COLLEGE

Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

NAME_________________________________________________ Date of Birth___________________

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? □ Yes □ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) □ Yes □ No

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of
Macedonia
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of
Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
Republic of
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) □ Yes □ No

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ Yes □ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? □ Yes □ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? □ Yes □ No

If the answer is YES to any of the above questions, Georgia Military College requires that you receive TB testing as soon as possible.

If the answer to all of the above questions is NO, no further testing or further action is required.

CONTACT GMC HEALTH SERVICES FOR ADDITIONAL INFORMATION/QUESTIONS:
(478) 387-4839