APPENDIX A

CALIFORNIA CADET CORPS	REPORT OF MEDICAL HISTORY	*FOR OFFICIAL USE ONLY*

NOTICE

The information requested below is required to provide the medical examiner an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the CACC training program. Also this information will be provided to medical examiners in case of injury or illness while participating in CACC activities. ***THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE***. *You are encouraged to consult your private physician regarding past illnesses. Proof of immunization for Polio, Measles, Mumps, Rubella and Diphtheria, Pertussis and Tetanus (DPT) plus Diphtheria and Tetanus (DT) booster may be required. Please attach a photocopy of the cadet's health insurance card, if available.*

1a. *School Name and Battalion # (if known)*	***1b.*** *Grade*

2a. Last Name	**2b.** First Name	**2c.** MI	**2d.** Rank

2e. Age	**2f.** Date of Birth (DDMMYY)	**2g.** Sex ☐ Male ☐ Female	**2h.** Parent/Guardian Name

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

2m. Home Phone	**2n.** Name of Health Insurance Provider	**2o.** Health Insurance identification number or plan number (please attach a copy of the Health Plan ID card if available)

3. CURRENT MEDICATION *(prescription and over-the-counter)*	**4.** ALLERGIES (including insect bites/stings, medicine, and other substances)

5. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 6)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	**YES**	**NO**		**YES**	**NO**
5a. Tuberculosis	☐	☐	**5n.** Head injury, memory loss, or amnesia	☐	☐
5b. Lived with someone with Tuberculosis	☐	☐	**5o.** Seizures, convulsions, epilepsy, or fits	☐	☐
5c. Asthma or breathing problems related to exercise, pollen, etc.	☐	☐	**5p.** Car, train, sea, and/or air sickness	☐	☐
5d. Been prescribed or use an inhaler	☐	☐	**5q.** A period of unconsciousness	☐	☐
5e. Loss of vision in either eye	☐	☐	**5r.** Heart trouble or murmur	☐	☐
5f. Loss of hearing or wear a hearing aid	☐	☐	**5s.** Received counseling for emotional or behavior disorder	☐	☐
5g. Impaired use of arms, legs, hands, feet	☐	☐	**5t.** Eating disorder (bulimia, anorexia)	☐	☐
5h. Knee problems	☐	☐	**5u.** Sleepwalking	☐	☐
5i. Broken bones(s) (cracked or fractured)	☐	☐	**5v.** Bedwetting	☐	☐
5j. Diabetes	☐	☐	**5w.** Been hospitalized *(if yes, why, when, where)*	☐	☐
5k. Anemia (including sickle cell)	☐	☐	**5x.** Any illness or injury not mentioned above *(if yes, explain)*	☐	☐
5l. Dizziness or fainting spells (including after exercise)	☐	☐	**5y.** Advised to avoid certain physical activities *(if yes, explain)*	☐	☐
5m. Frequent or severe headaches	☐	☐	**5z. Note any dietary restrictions (e.g. diabetics)**		

6. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problems, name of doctor(s) and/or hospitals, treatment given and current medical status)*

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7. IMMUNIZATION RECORDS (Indicate date of last immunization and attach proof of immunization if available)

7a. Measles	**7b.** Rubella	**7c.** DPT/DT-Tetanus	**7d.** Mumps	**7e.** Polio	**7f.** TB Test	**7g.** Other

8. REMARKS (please include and other medical history that you or your physician deems important)

9. ENDORSEMENT

"I certify that to the best of my knowledge that the information provided is true and accurate and that I have disclosed all pertinent medical history"

9a. Parent/Guardian (Type or Print)	**9b.** Signature	**9c.** Date (DD MMM YY)

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