Instructions for providing the required cadet physical and immunization forms.

May 2019

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 one of the U.S. Service Academy Preparatory Programs, 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: Included is the tuberculosis screening form, and to verify that further screening is not necessary. This form should be completed by the cadet prior to arrival on campus.

Phone: (478) 387-4839   Fax: (478) 445-1928
### 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 _______ Age __________ Date of birth_________________</td>
</tr>
<tr>
<td>Grade- Freshman / Sophomore</td>
<td>Sport________________________________________________</td>
</tr>
<tr>
<td>Home Address______________________________</td>
<td>Phone____________________</td>
</tr>
<tr>
<td>Insurance information: Company Name________________ Policy#________________ Group#________________</td>
<td></td>
</tr>
</tbody>
</table>

**In case of emergency, contact:**

| Name ________________________ Relationship_____________ | Phone (H)_________________ Phone(Cell)___________________ |

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

**FEMALES ONLY**

16. Have you ever had a menstrual period stop due to extended exercise? **YES / NO**
Explain fully, all "YES" answers

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

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_________________

Phone: (478) 387-4839   Fax: (478) 445-1928
# GMC Cadet Physical
## PHYSICAL EXAMINATION FORM

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/arm</td>
<td></td>
<td></td>
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<tr>
<td>Elbow/forearm</td>
<td></td>
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<tr>
<td>Wrist/hand/fingers</td>
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<tr>
<td>Hip/thigh</td>
<td></td>
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<tr>
<td>Knee</td>
<td></td>
<td></td>
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<tr>
<td>Ankle/foot</td>
<td></td>
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</tr>
</tbody>
</table>

**NORMAL** **ABNORMAL FINDINGS**

INITIALS*
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____________________
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 35 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:
  o the availability of a safe and effective vaccine
    http://www.cdc.gov/nip/publications/VIS/vis-mening.pdf,
  o 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?  □ Yes □ No
(If yes, please CIRCLE the country, below)

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

☐ 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