New Mexico Military Institute
Medical Packet - Marshall Infirmary

Incoming Cadets and Parents:

1. Please complete the attached **Medical Information**, **Medical History**, and **Insurance** forms, and ask your physician (NP, PA, MD or DO) to complete the **Physical Examination** and **Immunization** forms. Positive answers on the History & Physical forms must be fully explained, both to determine whether you meet physical qualifications for New Mexico Military Institute and to guide the Infirmary staff in providing care should you become ill or injured while a cadet. If you have already completed a DoDMERB physical, please see section 5, below.

2. **Medical forms** are due by ***May 1st.*** Additional medical or surgical information may be requested based on your history & physical exam forms. Some conditions will require a note from your doctor clearing you for unrestricted physical activity. When requested, ***supplemental medical information*** (doctor's summary, clearance to participate in all activities, etc.) must be provided as soon as possible, but absolutely no later than ***July 1st.*** Your application will not be complete until we receive all the requested information. You will be considered medically disqualified after July 1st unless we receive all necessary information.

3. **Medical clearance is required** for an applicant to attend New Mexico Military Institute. However, we can approve **waivers** for some minor disqualifying medical conditions. Mild asthma, occasional migraine headaches, ADD/ADHD, and mild depression or anxiety are among the common conditions which can be waived. If you have questions about whether a medical condition can be waived, please contact NMMI Marshall Infirmary by e-mail (pittman@nmmi.edu) or call the number below as early as possible.

4. **Immunizations are REQUIRED** for students to attend school in the state of New Mexico. You must review the NM Department of Health required immunizations and complete these **PRIOR** to your attendance at NMMI. If you wish to decline immunizations, you must complete a Certificate of Exemption Form with the NM Department of Health. The form requires a statement of the religious reasons for requesting to have a child exempted from immunization.
The law does not grant immunization exemptions for philosophical or personal reasons. Once a completed, notarized, original Certificate of Exemption Form is filed with the Department of Health, the Department has up to sixty days to notify the parent/guardian if the request is approved or denied. www.nmhealth.org Please see attached immunization requirement.

5. DD Form 2351, "DoDMERB Report of Medical Examination," and DD Form 2492, "DoDMERB Report of Medical History," are acceptable in place of the NMMI physical exam and history forms. All other NMMI forms ("Medical Information," "Medical Insurance," and "Immunizations") must be submitted along with the DD Forms. The DD forms must include height, weight, and blood pressure. **If you plan to participate in athletic sports you will still be required to complete the NMMI Medical forms and physical.**

6. If you develop a **significant illness** or **injury** after submitting your medical forms, please ask your doctor to send a short, interim report describing your current medical status and anticipated status at matriculation. These **Interim reports** must be received ***as soon as possible*** after the illness or injury; your application will not be complete until we receive them.

7. **Insurance is REQUIRED** of all cadets attending NMMI. You must submit copies of your insurance or **supplemental health insurance** (either family policy or individual student policy)**.** Please note foreign insurance policies and some out of state Medicaid policies are not accepted by local physicians and pharmacies. It is your responsibility to know your insurance coverage.

8. **Medications** are not permitted to be stored in cadet rooms. Cadets may store medications at Marshall Infirmary. Cadets will have access to the cadet clinic and physician. We will work with cadets and parents to refill prescriptions and refer to specialty care if needed. It is the cadet's responsibility to cover any financial cost associated with referred care off post or prescriptions.

9. Please note that **failure** to report significant pre-existing **medical** or **psychiatric conditions** will be ***grounds for termination*** **of your cadet career**, with forfeiture of tuition and fees. This applies to active conditions which could affect participation in military, athletic and/or academic programs, as well as past medical or psychiatric conditions.

If you have questions about medical forms, medical clearance, Infirmary services, etc., please call **(575) 624-8235,** between 08:30 am and 3:00 pm, Monday through Friday. E-mail: **nurse@nmmi.edu**. Our FAX # is **(575) 624-8235**.

New Mexico Military Institute – Medical Insurance Information

Student Info

- Full Name _____
- Social Security Number _____
- Date of Birth _____

Policy Holder Info

- Policy Holder Name _____
- Holder's Date of Birth _____
- Holder's Address _____
- City _____ State _____ Zip _____
- Holder's Phone _____

Insurance Company Info

- insurance Co Name _____
- Company Address _____
- City _____ State _____ Zip _____
- Phone number _____
- Policy number _____
- Group Number _____
- Attach photocopy of insurance card (front and back)

Military Dependents

- Military dependent covered by TRICARE: _____Yes _____No
- If "Yes" please provide sponsor's SSN: _____
- Please check which coverage: _____Tricare Standard _____Tricare Prime
- Please attach a photocopy of Tricare Card front and back

Certification and Consent

- I understand that all cadets must carry supplemental health insurance for the entire period of enrollment at NMMI, in order to avert financial hardship due to hospital admissions, emergency department care, subsequent care, or other medical services not available at NMMI. I will notify the infirmary of any changes to insurance coverage as soon as they occur.
- I further understand that my signature, below, grants permission for NMMI and Sports medicine staff to treat my son or daughter for routine medical conditions.
- Parent Signature _____ Date _____

New Mexico Military Institute
MEDICAL INFORMATION
(This page completed by applicant)

PLEASE PRINT: DATE (mm/dd/yy)_____/_____/_____

_____ _____
NAME: Last First Middle Social Security Number (SSN)

_____
Street Address City State Zip

_____ _____
Home Phone Work Phone Date of Birth (mm/dd/yy) Sex (M / F)

_____
Father's Name Mother's Name

_____
Email address

_____
Emergency Contact Name Emergency Phone #

Military dependent: YES / NO If "Yes" give sponsor's SSN: _____

TRICARE Standard_____TRICARE Prime (Charleston PCM only) _____

Medications: Do you take any medications on a regular basis? If so, please list them here:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Notes:

1. Failure to report all current and previous physical & mental conditions will be grounds for medical review and possible termination of your cadet career with forfeiture of appropriate tuition and fees.

2. Cadets must complete all physical aspects of the Recruit At Training Period (first 21 days of school). This includes running, sit-ups, push-ups, running up/down stairs, rifle manual, marching in formation, and a variety of other physical activities. Because initial cadet training is only offered once, Cadets who miss more than 30% of this training period due to injury or illness will be referred for medical review and possible medical discharge for the semester.

New Mexico Military Institute
MEDICAL HEALTH AND CONSENT

(This page completed by applicant)

PLEASE PRINT

NAME: LAST **FIRST** **M.I.** **Date of Birth**

Have you ever had, or do you now have, any of the following? If "Yes", please explain under "Remarks."

Yes	No	(Check each item)	Yes	No	(Check each item)
		Dizziness, loss of consciousness, or fainting			Eating disorder (anorexia, bulimia)
		High blood pressure or stroke			Eye problems or vision changes
		Hay fever or seasonal allergies			Wears glasses or contact lenses
		Reactions to medications, foods, bugs			Hearing loss or recent ear infections
		Surgery, or consult with a surgeon			Visit to a rheumatologist
		Concussions or head injuries			Frequent persistent colds
		Frequent or severe headaches, migraines			Sinus infections/sinusitis
		Dental pain, tooth or gum problems			Mouth or nose problems
		Epilepsy, seizures, convulsions, or fits			Tooth or gum problems
		Scarlet fever, rheumatic fever			Thyroid or throat problems
		Tumor, cysts, unusual growth or cancer			Problems w/ testicles, scrotum, penis
		Visit to a cardiologist or heart specialist			Problems with menses, breast, paps
		Chest pain or pressure, palpitations			Muscle weakness, paralysis, lameness
		Heart problems (murmur, rhythms)			Painful or swollen joints
		Shortness of breath with exercise			Dislocations
		Asthma (reactive airways), recurrent wheeze			Bone problems, bone fractures
		Chronic cough, lung disease, bronchitis			Back or neck pain
		Tuberculosis, or close contact with persons			Wears a brace or splint
		Diabetes, blood sugar too high, too low			Bone or joint deformity
		Stomach, liver, gall bladder problems			Leg cramps or persistent foot pain
		Hepatitis, jaundice, liver problems			Attempted suicide, thoughts of suicide
		Gastroesophageal reflux/GERD			Depression, excessive worry, anxiety
		Intestinal disease (Crohn's disease, UC)			Bipolar disorder, schizophrenia, psychosis
		Coughed up blood or committed blood			ADD/ADHD learning disability, speech
		Hemorrhoids, or rectal disease			Visit to psychiatrist, counselor, therapist
		Black or bloody stools			History of self-harming, "cutting"
		Kidney stones, kidney infections or problems			Excess bleeding, easy bruising, clotting
		Frequent or painful urination, blood in urine			Visit to a hematologist or oncologist
		Hernia or rupture			Skin problems
		Other significant illness / surgery			Current wounds

Explain each "Yes" above:

_____

_____

_____

_____

_____

_____

_____

(Continue to page 2)

I. INFLUENZA VACCINATION

- **_____I DO GIVE CONSENT FOR INFLUENZA VACCINE**
- **_____I DO NOT GIVE CONSENT FOR INFLUENZA VACCINE**
- I authorize NMMI Infirmary to administer the influenza vaccine on a yearly basis while the applicant is attending NMMI. In the event of an infectious disease outbreak, i.e. influenza, etc. NMMI will coordinate parental notification of those cadets without parental authorization through local public health agencies. Cadets refusing mandatory immunization during an outbreak may be immediately disenrolled from NMMI upon counsel of the New Mexico Department of Health.

II. DISQUALIFYING CONDITIONS – the following conditions are considered disqualifying for admission.

- Epilepsy or previous seizures with current treatment
- Diabetes requiring special diet and insulin therapy
- Blindness
- Deafness
- Chronic renal disease
- Chronic cardiac disease
- Severe symptomatic asthma
- Any severe neuromuscular or orthopedic disease which would interfere with the cadet's performance and physical activity in accordance with NMMI requirements.
- Any other substantial physically- or mentally-limiting condition which, in the opinion of the medical staff, would interfere with the cadet's ability to function satisfactorily.

III. BEHAVIORAL STANDARDS considered disqualifying for admission

- Any felony criminal conviction or probationary conviction
- Any permanent dismissal from any school or suspensions within the last three years
- Any attempted suicide
- Manic depressive disorder, bipolar disorder, regularly scheduled psychological counseling or any other severe psychological disorders or limiting condition which in the opinion of medical staff interferes with the cadet's ability to function satisfactorily at NMMI, demonstrate an inability to meet the existing NMMI admission requirements without significant accommodation that would alter the missions of the institute
- Drug addictions or alcohol addiction

IV. CONSENT

- **I do hereby give permission to New Mexico Military Institute – Marshall Infirmary health care professionals and / or NMMI contracted health care staff – to treat my son/daughter/myself on a routine and emergency basis. I also authorize the New Mexico Military Institute employed or contracted health care professionals to refer my son/daughter/myself to an appropriate local health care facility/office in the Roswell community, the Eastern New Mexico Medical Center or Lovelace Hospital for further evaluation, treatment, or hospitalization as deemed necessary. Failure to disclose all medical conditions could result in denial of admission**

Date:_____ _____
Signature of Applicant

Phone:_____ _____
Signature of Guardian

Address_____ _____
Date

_____ _____
Email

In the event you would like to call the infirmary to receive information about your cadet, please provide a password for your cadet's protected health information:_____

New Mexico Military Institute
PHYSICAL EXAMINATION
(To be completed by Physician MD or DO)

PLEASE PRINT

NAME: Last First Middle _____ **Date of Birth** _____

Height:_____ **Weight:**_____ **Blood Pressure:**_____ **Pulse:**_____

Distant Vision: **UNCORRECTED:** **Right 20/**_____ **CORRECTED:** **20/**_____

Left 20/ _____ **20/**_____

PHYSICAL EXAMINATION: Please describe each abnormality in the REMARKS section.

Normal	Abnormal		Normal	Abnormal	
		Head, face, neck, scalp			G-U
		Eyes			Hernia
		Ears and hearing			Rectal (visual inspection only)
		Nose and Sinus			Spine (motion, flexibility)
		Mouth, throat, teeth, jaw			Upper extremities
		Neck and thyroid			Lower extremities
		Lungs and chest			Feet
		Heart			Neurological
		Vascular system			Skin
		Abdomen and viscera			Tattoos (size and location)

Physician, please describe any noted abnormalities in detail:

_____

_____

_____

_____

_____

_____

Physician: Please ensure that ALL ITEMS, on BOTH pages of the H&P are completed before signing.

Doctor's Signature_____**MD/DO** **Date**_____

Printed Name_____ **Phone**_____

Office Address_____

IMMUNIZATION RECORD

Applicant's Name_____ Date of Birth_____

The following immunizations are required, recommended, or suggested for cadets enrolled at NMMI. This form must be completed and signed by the applicant's physician.

Please provide a copy of your original immunization cards from your physician's office or health department.

Vaccine	Write Date Administered: (Each box represents dose required)				
DtaP					
Polio					
Hep B					
MMR					
Varicella					
Tdap					

Tuberculin Test PPD: (Required only for applicants who live overseas/outside country)

Date of test___/___/___

Negative___Positive____

Chest XRAY if positive _____

Treatment if any _____

Meningococcal Vaccine is not required by highly recommended and should be consider for all students.

_____

Physician's Signature

_____

Printed Name

_____

City, State, Zip

_____

Date