Do not mail this page as part of your package!

Naval Reserve Officers Training Corps (NROTC)
New Student Indoctrination (NSI) Package Checklist

OMB CONTROL NUMBER: 0703-0026
OMB EXPIRATION DATE: 01/31/2026

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information, OMB-0703-0026, is estimated to average 3 hours and 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that, notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR RESPONSE TO THE EMAIL ADDRESS ABOVE.

Responses should be sent to:

Naval Service Training Command
Candidate Midshipman Guidance Office (CMGO)
Building 3, Room 106
320A Dewey Avenue
Great Lakes, IL 60088-2911

MAIL YOUR PACKAGE TO THIS ADDRESS VIA US POSTAL SERVICE FLAT RATE MAIL, YOU WILL RECEIVE A TRACKING #. KEEP A COPY FOR YOUR RECORDS!

PLEASE READ THE FOLLOWING STATEMENT REQUIRED BY THE PRIVACY ACT OF 1974 BEFORE COMPLETING THE APPLICATION.

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. § 301, Departmental Regulations; 10 U.S.C. 2107 (Financial Assistance Program); E.O. 9397 (SSN), and System of Records Notices (SORNs) N01130-1 and N01080-3.

PURPOSE(S): To manage and contribute to the recruitment of qualified men and women for officer programs and the regular and reserve components of the Navy. To ensure quality military recruitment and to maintain records pertaining to the applicant's personal profile for purposes of evaluation for fitness for commissioned service. The information you provide will be used to determine whether you qualify, and should be nominated for, an NROTC Scholarship. If you are nominated, the information will be used to enroll you into NROTC and will be used by the Navy in its management of the NROTC program.

ROUTINE USE(S): Information provided on the application will be used to screen and select individuals to receive scholarships, maintain data on the scholarship program, compare scholarship applicants from previous or subsequent years, and provide academic data and contact information to Navy activities and admissions officials at colleges and universities for recruitment purposes. Other uses may include providing the information to officials and employees of: the Department of Transportation; other agencies of the Executive Branch upon request in relation to the management of quality of military recruitment; the Department of Veterans Affairs and Selective Service Administration in relation to enlistment or reenlistment eligibility; Federal, state or local agencies that maintain civil, criminal and other relevant information pertaining to the letting of contracts; in response to an inquiry from a congressional office of record for an individual; to the Office of Personnel Management (OPM) to carry out legally authorized government-wide personnel management functions and studies; and to the General Services Administration (GSA) for the purposes of records management under the authority of 44 USC § 2904 & 2906. Information provided in this application is protected by the Privacy Act and will not be released outside of the Department of Defense without your permission, unless it comes with an exception to the Act, or one of the routine uses in 32 C.F.R. § 701.112, https://www.navy.mil/privacy.asp, and the routine uses set forth here. If you are nominated for an NROTC Scholarship, the information will be released to the top five schools you indicated on your application. Your information and notification of status may also be provided to your high school so they may assist with the final stages of the process.

DISCLOSURE: Voluntary - However, failure to do so may result in our inability to process your application for the NROTC program. Note that the Social Security number (SSN) is required at the time of application to ensure proper identification of the applicant. There are times applicants have the same names, therefore the collection of SSN is required to ensure proper identification.

More information on the SORNS can be found at the following link(s):
http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentArticleView/tabid/7489/Article/6411/n01131-1.aspx,
http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentArticleView/tabid/7489/Article/6410/n01080-3.aspx.

Initial in each box to certify that the MANDATORY documents listed are contained within your NSI submission package. Affix this completed page to the top of your submission package, and mail to the address above. All medical documentation must include legal first and last names and date of birth.

INITIALS	DOCUMENTS INCLUDED
JD	1533/174 NSI New Student Information Sheet
JD	1533/173 NROTC Standard Release Form
JD	American Academy of Family Physicians Preparticipation (Sports) Physical Evaluation History (2023) AND Physical Examination Forms, 2019 version (This is a 4 page document that is valid for 365 days and must not expire during NSI)
	Copy of immunization record with documentation of the four (4) following vaccines:
JD	*One Dose of ACWY Meningococcal Vaccine (for example MCV vaccine) on or after 16th birthday
JD	*Two Doses of Mumps, Measles, Rubella (MMR) Vaccine at least 28 days apart
JD	*Two Doses of Varicella (Chicken Pox) Vaccine or Titer Test From Lab Documenting Immunity
JD	*One Dose of TDaP Vaccine within the last 10 years
JD	Newborn Sickle Cell Blood Test Provider notes stating a student's Sickle Cell Trait status **WILL NOT** be accepted, only lab results.

Candidate Signature: John Doe Digitally signed by John Doe Date: 2023.10.25 09:39:17 -05'00' Date: 11/15/23

THIS IS A FILLABLE FORM WHICH CAN ALSO BE SIGNED DIGITALLY. YOU MAY ALSO WET SIGN THIS FORM + WET INITIAL.

Do not mail this page as part of your package!

NROTC NEW STUDENT INDOCTRINATION (NSI) INFORMATION SHEET

OMB CONTROL NUMBER: 0703-0026
OMB EXPIRATION DATE: 01/31/2026

AGENCY DISCLOSURE NOTICE:
The public reporting burden for this collection of information, OMB-0703-0026, is estimated to average 3 hours and 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE READ THE FOLLOWING STATEMENT REQUIRED BY THE PRIVACY ACT OF 1974.

PRIVACY ACT STATEMENT
AUTHORITY: 5 U.S.C. § 301 (Authorizing Departmental Forms and Regulations); 10 U.S.C. § 2107 (Financial Assistance Program); and Executive Order 9397 (Use of Social Security Numbers), and System of Records Notice(s) (SORN) N01131-1.and N0180-3.

PURPOSE(S): The primary use of this information is for officials to administer the Naval Reserve Officers Training Corps (NROTC) Program, and to set forth the terms and conditions, including military service obligations, under which the Navy will be providing an NROTC scholarship. The information will be used to determine whether you qualify, and should be nominated for, an NROTC Scholarship. If you are nominated, the information will be used to enroll you into NROTC and will be used by the Navy in its management of the NROTC program.

ROUTINE USE(S): These records or information contained therein may be disclosed outside the Department of Defense to officials and employees of the college or university in which you enroll, and those of the Veterans Administration, and Selective Service Administration in the performance of their official duties related to enlistment and reenlistment eligibility and related benefits. Other uses may include - Providing information to officials and employees of the Department of Transportation, and other agencies of the Executive Branch upon request in relation to the management of quality of military recruitment; the Department of Veterans Affairs and Selective Service Administration in relation to enlistment or reenlistment eligibility; Federal, state or local agencies that maintain civil, criminal and other relevant information pertaining to the letting of contracts; in response to an inquiry from a congressional office of record for an individual; to the Office of Personnel Management (OPM) to carry out legally authorized government-wide personnel management functions and studies; and to the General Services Administration (GSA) for the purposes of records management under the authority of 44 USC § 2904 & 2906. Information provided may be used to screen and select individuals to receive NROTC Scholarships, to maintain data on the NROTC scholarship program, to compare to scholarship applicants from previous or subsequent years, and to provide academic data and contact information to Navy activities and admissions officials at colleges and universities so they can contact applicants for recruitment purposes. If you are nominated for an NROTC Scholarship, the information will be released to the top five schools you indicated on your application. Your information and notification of status may also be provided to your high school so they may assist with the final stages of the process. Information provided on this form is protected by the Privacy Act and will not be released outside of the Department of Defense without your permission, unless it comes with an exception to the Act, or one of the routine uses in 32 C.F.R. § 701.112, https://www.navy.mil/privacy.asp, and the routine uses set forth here.

DISCLOSURE: Voluntary. However, failure to provide the requested information may result in ineligibility for, and/or disenrollment from, the NROTC Program.

More information on the SORNS can be found at the following link(s):
http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentArticleView/tabid/7489/Article/6411/n01 131-1.aspx,
http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentArticleView/tabid/7489/Article/6410/n01080-3.aspx.

Please complete all items legibly.

All fields ARE REQUIRED to register NSI participants in training and healthcare systems prior to the start of training.

Last Name: Doe First Name: John Middle Initial: A

Email Address: john.doe@gmail.com

Social Security Number:
Enter FULL 9 digit number 123-45-6789

Date of Birth:
Enter as MM/DD/YYYY 11/15/2007

Place of Birth: Any Town, IL

Marital Status:
Single, Married, Divorced, Widowed Single

Ethnicity:
Check the boxes below

Ethnic Code: You may select as many of the ethnic categories that you feel apply to you.

☐ (1) Other Hispanic Descent	☐(6) Mexican	☐(G) Chinese	☐(S) Latin American with Hispanic Descent
☐(2) U.S./Canadian Indian Tribes	☐(7) Eskimo	☐(H) Guamanian	☐(V) Vietnamese
☐(3) Other Asian Descent	☐(8) Aleut	☐(J) Japanese	☐(W) Micronesian
☐(4) Puerto Rican	☐(9) Cuban	☐(K) Korean	☒(X) Caucasian/White
☒(5) Filipino	☐(D) Indian/Pakistani	☐(L) Polynesian	☐(Y) Other
	☐(E) Melanesian	☐(Q) Other Pacific Island Descent	

Religious Preference: No religious preference

Gender (for berthing purposes): Male

Home of Record (HOR)
(Often Parent's address):

Street 123 Any Street

City, State, ZIP Code Any Town, IL 00000

Cell Phone #: (123) 555-1234

Residence Phone #:

Parent/Guardian 1 Full Name: Jane Doe

Address (If different from above):

Parent/Guardian 1 Contact Phone #: (123) 555-5555 Phone Type? Mobile

Parent/Guardian 2 Full Name: James Doe

Address (If different from above):

Parent/Guardian 2 Contact Phone #: (123) 555-2345 Phone Type? Mobile

NROTC OPTION: Check one ☒ Navy ☐ Nurse ☐ Marine Corps

Date of High School Graduation: 06/15/24

Do you have any commitments that prevent you from attending any of the NSI training iterations? ☒ YES ☐ NO

If YES, for which dates are you unavailable? High school during NSI 1. Available for NSI 2. Family vacation overseas during NSI 3.

DoD Identification Number (for military dependents only): Not Applicable

Midshipman Candidate Signature: John Doe Digitally signed by John Doe Date: 2023.10.25 09:48:36 -05'00' Date: 11/15/2023

Printed Name: John Doe

THIS FILLABLE FORM CAN BE WET SIGNED OR DIGITALLY SIGNED.

Do not mail this page as part of your package!

NAVAL RESERVE OFFICERS' TRAINING CORPS (NROTC)
STANDARD RELEASE FORM

OMB CONTROL NUMBER: 0703-0026
OMB EXPIRATION DATE: 01/31/2026

AGENCY DISCLOSURE NOTICE:
The public reporting burden for this collection of information, OMB-0703-0026, is estimated to average 3 hours and 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE READ THE FOLLOWING STATEMENT REQUIRED BY THE PRIVACY ACT OF 1974.

PRIVACY ACT STATEMENT
AUTHORITY: 5 U.S.C. § 301 (Authorizing Departmental Forms and Regulations); 10 U.S.C. § 2107 (Financial Assistance Program); and Executive Order 9397 (Use of Social Security Numbers), and System of Records Notice(s) (SORN) N01131-1.and N0180-3.

PURPOSE(S): The primary use of this information is for officials to administer the Naval Reserve Officers Training Corps (NROTC) Program, and to set forth the terms and conditions, including military service obligations, under which the Navy will be providing an NROTC scholarship. The information will be used to determine whether you qualify, and should be nominated for, an NROTC Scholarship. If you are nominated, the information will be used to enroll you into NROTC and will be used by the Navy in its management of the NROTC program.

ROUTINE USE(S): These records or information contained therein may be disclosed outside the Department of Defense to officials and employees of the college or university in which you enroll, and those of the Veterans Administration, and Selective Service Administration in the performance of their official duties related to enlistment and reenlistment eligibility and related benefits. Other uses may include - Providing information to officials and employees of the Department of Transportation, and other agencies of the Executive Branch upon request in relation to the management of quality of military recruitment; the Department of Veterans Affairs and Selective Service Administration in relation to enlistment or reenlistment eligibility; Federal, state or local agencies that maintain civil, criminal and other relevant information pertaining to the letting of contracts; in response to an inquiry from a congressional office of record for an individual; to the Office of Personnel Management (OPM) to carry out legally authorized government-wide personnel management functions and studies; and to the General Services Administration (GSA) for the purposes of records management under the authority of 44 USC § 2904 & 2906. Information provided may be used to screen and select individuals to receive NROTC Scholarships, to maintain data on the NROTC scholarship program, to compare to scholarship applicants from previous or subsequent years, and to provide academic data and contact information to Navy activities and admissions officials at colleges and universities so they can contact applicants for recruitment purposes. If you are nominated for an NROTC Scholarship, the information will be released to the top five schools you indicated on your application. Your information and notification of status may also be provided to your high school so they may assist with the final stages of the process. Information provided on this form is protected by the Privacy Act and will not be released outside of the Department of Defense without your permission, unless it comes with an exception to the Act, or one of the routine uses in 32 C.F.R. § 701.112, https://www.navy.mil/privacy.asp, and the routine uses set forth here.

DISCLOSURE: Voluntary. However, failure to provide the requested information may result in ineligibility for, and/or disenrollment from, the NROTC Program.

More information on the SORNS can be found at the following link(s):
http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentArticleView/tabid/7489/Article/6411/n01 131-1.aspx,
http://dpclo.defense.gov/Privacy/SORNsIndex/DODComponentArticleView/tabid/7489/Article/6410/n01080-3.aspx.

FILL IN HIGH LIGHTED AREAS (WE ARE HARD TO SEE)

1. I, John Doe, a Midshipman Candidate (MC) of the Naval Reserve Officers Training Corps (NROTC), in consideration of basic participation in NROTC sponsored extracurricular activities, to wit NROTC New Student Indoctrination in June, July, or August 2024, do hereby release the government of the United States and all its officers, representatives, and agents acting officially, and also all local, regional, and national Navy Officials of the United States, from any and all claims, demands, actions, or causes of action, death, injury, or illness, except as provided under 10 USC 1074b, Medical and dental care: Academy cadets and midshipmen; members of, and designated applicants for membership in, Senior ROTC.

I hereby authorize personnel of the Department of the Defense, Armed Forces, Public Health Service, and/or civilian physicians, to render such medical and dental care as may be necessary and medically indicated in my case during this period of activity, as is deemed necessary by a qualified practitioner.

I understand that if I am injured in the line of duty during this training evolution, I may file a claim under the Federal Employee's Compensation Act (FECA 5 USC 8101, et seq.). The claim will be administered by the U.S. Department of Labor (DOL). If any such claim is denied, I may be responsible for the cost of all medical care.

I understand that care at a military medical treatment facility (MTF) for non-military dependents will be rendered on a temporary (emergency) basis only; if further care is indicated, I will be transferred to non-military care as soon as possible. Emergency care provided at an MTF to MC who are not military dependents may be subject to reimbursement, and I may be billed for the care provided. For Navy MTF, such care is authorized by BUMED INSTRUCTION 6320.103.

I have no known medical conditions that might preclude, or limit in any way, participation in NROTC sponsored extracurricular activities.

HIPAA Privacy Authorization Form for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability Act (HIPAA)
45 CFR Parts 160 and 164

Authorization

I authorize NSI personnel and/or a Federal Health Care Center (FHCC) to use and disclose my Protected Health Information (PHI) described below to the entity(ies) noted below:

BUMED
FAX: 571-316-1527
OR VIA
DOD SAFE (https://safe.apps.mil/)

DoDMERB
email: dha.ncr.dod-merb.mbx.helpdesk@health.mil

For additional recipients:
Provide Name, Address, Contact Telephone Number, and Relationship to yourself for each authorized individual)

1. Jane Doe
123 Any Street
Any Town, IL 00000
(123) 555-5555
Mother

2. Effective Period

This authorization for release of information covers the period from:

a. ■ 11/15/2023 to 9/15/2023. HIGHLY RECOMMEND USING THESE DATES, SO WE CAN COMMUNICATE YOUR PERSONAL HEALTH INFORMATION FOR A LIMITED TIME BEFORE + AFTER NSI ONLY.

OR

b. ☐ All past, present, and future periods.

3. Extent of Authorization

a. ■ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). HIGHLY RECOMMEND SELECTING THIS OPTION, SO MEDICAL PROVIDERS HAVE YOUR COMPLETE MEDICAL PROFILE.

OR

b. ☐ I authorize the release of my complete health record with the ***exception*** of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the individual(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: John Doe (THIS MUST BE A WET SIGNATURE. A DIGITAL SIGNATURE WILL NOT BE ACCEPTED).

Printed name: John Doe

Date: 11/15/2023

CONSENT OF PARENT(S) OR GUARDIAN(S)

(To be completed and notarized if the MC is under 18 years of age)

I certify that I am the parent or legal guardian of the MC who has signed this form in the above signature block.

I have read and understand this form.

(THIS MUST BE A WET SIGNATURE. A DIGITAL SIGNATURE WILL NOT BE ACCEPTED).

Parent/Guardian Signature: Jane Doe

Printed Name: Jane Doe

Address: 123 Any Street, Any Town, IL 00000

Telephone: (123) 555-5555 (Mobile) mobile or landline? (Circle Type)

Notary Public Verification of Parent/Legal Guardian Signature

State of Illinois
County of Lake

Signed and sworn (or affirmed) before me on the 15th day of November, 2023.

[SEAL]

Official Seal
MATTHEW LAING
Notary Public, State of Illinois
Commission No. 899472
My Commission Expires August 12, 2027

Signature of Notary Public

Title of Office: Notary Public
My commission expires: 8/12/2027

IF YOU ARE UNDER THE AGE OF 18 ON THE DAY YOU SIGN THE PREVIOUS PAGE (3 OF 4), YOUR PARENT/GUARDIAN MUST WET SIGN THIS FORM + HAVE IT NOTARIZED.

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: (Type or print legibly) Date of birth: Month Date, Year

Date of examination: Month Date, Year (must match the date your doctor signed the exam) Sport(s): NROTC

Sex assigned at birth (F, M, or intersex): F, M, I How do you identify your gender? (F, M, non-binary, or another gender): F, M, I

Have you had COVID-19? (check one): ☐ Y ☐ N Answer these COVID questions as applicable.

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) Month Date, Year (if applicable)

List past and current medical conditions. (include month/year)

If you have none, state NONE or N/A. If you leave this answer blank, your package will be incomplete.

Have you ever had surgery? If yes, list all past surgical procedures. (include month/year)

If you have none, state NONE or N/A. If you leave this answer blank, your package will be incomplete

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

If you aren't taking any, state NONE or N/A. If you leave this answer blank, your package will be incomplete.

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

If YES, list all allergies, describe your reaction. Did you have an anaphylactic episode? Do you require an epipen?

If you don't have any allergies, state NONE or N/A. If you leave this answer blank, your package will be incomplete.

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		X
2. Has a provider ever denied or restricted your participation in sports for any reason?		X
3. Do you have any ongoing medical issues or recent illness?		X
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		X
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		X
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		X
7. Has a doctor ever told you that you have any heart problems?		X
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		X

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		X
10. Have you ever had a seizure?		X

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			X
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			X
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			X

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	X	
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		X
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		X
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		X
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		X
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		X
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		X
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		X
22. Have you ever become ill while exercising in the heat?		X
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		X
24. Have you ever had or do you have any problems with your eyes or vision?		X

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		X
26. Are you trying to or has anyone recommended that you gain or lose weight?		X
27. Are you on a special diet or do you avoid certain types of foods or food groups?		X
28. Have you ever had an eating disorder?		X

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?	X		
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

Question 14. Tore right pectoral muscle (9/2021). Underwent physical therapy 10/2021 to 1/2022, Cleared by PCM to participate in sports 1/2022.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: You must sign this form.

Signature of parent or guardian: Your parent or guardian signs here, if you are under 18 on the day you sign this form.

Date: Month Date, Year (This date needs to be the same date as your physical or earlier).

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ (Type or print legibly) _____ Date of birth: Month Date, Year

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

Your doctor MUST answer all questions below.
Please refer to the examples below for clarification.

EXAMINATION		
Height: 5' 9" Weight: 175		
BP: 120/80 (/) Pulse: 62 Vision: R 20/25 L 20/30 Corrected: ☐ Y ☒ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☒ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☒ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	X	
Eyes, ears, nose, and throat • Pupils equal • Hearing	X	
Lymph nodes	X	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	X	
Lungs	X	
Abdomen	X	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	X	
Neurological Please ensure your doctor answered this box, many missed it in 2023.	X	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	X	
Back	X	
Shoulder and arm	X	
Elbow and forearm	X	
Wrist, hand, and fingers	X	
Hip and thigh	X	
Knee	X	
Leg and ankle	X	
Foot and toes		Ingrown toe nail on right toe
Functional Please ensure your doctor answered this box, many missed it in 2023. • Double-leg squat test, single-leg squat test, and box drop or step drop test	X	

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): Medical professional can also use a stamp here. Date: This date must be on or after 8/15/23

Address: Medical professional can print, type or stamp address and phone number Phone: _____

Signature of health care professional: Medical professional must sign this page , MD, DO, NP, or PA

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: Last Name, First Name (Type or print legibly) Date of birth: Month Date, Year

☐ Medically eligible for all sports without restriction Your doctor MUST declare your medical eligibility to participate from one (1) of these five (5) options.

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): Medical professional can also use a stamp here. Date: This date must be the same as the date on the previous page

Address: Medical professional can print, type or stamp address and phone number Phone: _____

Signature of health care professional: Medical professional must sign this page, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION Medical professional must include all known conditions below.

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: Who you want us to contact in case of an emergency.

_____

_____

PatientPortal

[redacted]

Your first and last names and date of birth must be on all pages you submit.

Patient	[redacted]	**Emergency Contact**	[redacted]
DOB	11/4/2004	**Relationship**	[redacted]
Address	[redacted]	**Phone**	[redacted]

Immunizations

Vaccine Group	Vaccine	Date
DTaP, unspecified formulation This is not the required TDaP shot. If you submit proof of this shot without TDaP, you will not be allowed to attend NSI.	DTaP	11/17/2009
	DTaP	5/5/2006
	DTaP	5/6/2005
	DTaP	3/4/2005
	DTaP	1/7/2005
Hep A, unspecified formulation	HepA 2dose	11/3/2006
	HepA 2dose	5/5/2006
Hep B, unspecified formulation	HepB	5/6/2005
	HepB	1/7/2005
	HepB	11/5/2004
Hib, unspecified formulation	HIB-PRP-T	2/3/2006
	HIB-PRP-T	5/6/2005
	HIB-PRP-T	3/4/2005
	HIB-PRP-T	1/7/2005
HPV, unspecified formulation	HPV9	6/8/2016
	HPV9	1/15/2016
	HPV9	11/23/2015

Vaccine Group	Vaccine	Date
influenza, unspecified formulation	FLU-IIV4 6m+ pf	11/8/2022
	FLU-IIV4 6m+ pf	12/29/2021
	FLU-IIV4 6m+ pf	12/22/2020
	FLU-IIV4 6m+ pf	12/20/2019
	FLU-IIV4 3yrs+	12/28/2018
	FLU-IIV4 3yrs+ pf	11/13/2017
	FLU-IIV3 3yrs+	12/22/2016
	FLU-IIV3 3yrs+	11/23/2015
	FLU - Nasal	11/17/2014
	FLU - Nasal	12/10/2013
	FLU - Nasal	11/27/2012
	FLU - Nasal	11/21/2011
	FLU - NOS	1/25/2011
	FLU - NOS	11/18/2010
	FLU - Nasal	11/17/2009
	FLU - NOS	11/14/2008
	FLU - NOS	11/8/2007
	FLU - NOS	2/3/2006
	FLU - NOS	11/11/2005
1. meningococcal ACWY, unspecified formulation You must provide proof of vaccination after your 16th birthday.	MCV4	12/22/2020
	MPSV4	11/23/2015
meningococcal B, unspecified This shot is not acceptable. If you send us proof of this shot without proof of the meningococcal ACWY vaccine, you will not be allowed to attend NSI.	MenB	12/29/2021
	MenB	12/22/2020
2. MMR Two doses, at least 28 days apart, is required for this vaccine.	MMR	11/17/2009
	MMR	11/11/2005
Pneumococcal Conjugate, unspecified formulation	PCV13	11/11/2005
	PCV13	5/6/2005
	PCV13	3/4/2005
	PCV13	1/5/2005

Your first and last names and date of birth must be on all pages you submit.

[redacted]

Vaccine Group	Vaccine	Date
polio, unspecified formulation	IPV	11/17/2009
	IPV	5/5/2006
	IPV	3/4/2005
	IPV	1/7/2005
SARS-COV-2 (COVID-19) vaccine, UNSPECIFIED	COVID19 30	6/13/2021
	COVID19 30	5/21/2021
Tdap	Tdap	11/23/2015
varicella	Var	11/17/2009
	Var	2/3/2006

3. Tdap You are required to present proof of vaccination within the last 10 years.

4. varicella You are required to present proof of vaccination or a lab result of a titer showing you have had chicken pox and are immune. Provide proof of having received 2 shots, at least 28 days apart.

Your first and last names and date of birth must be on all pages you submit.

[redacted]

DEPARTMENT OF HEALTH SERVICES
NEWBORN SCREENING PROGRAM
850 MARINA BAY PARKWAY, ROOM F175
RICHMOND, CA 94804
(510) 412-1502

NEWBORN SCREENING RESULTS - INITIAL

MONTEREY PENINSULA COMM HOSP
LABORATORY
BOX H H
MONTEREY, CA 93942

BABY
[redacted]

MOTHER
[redacted]

SPECIMEN COLLECTION SITE
[redacted]

NEWBORN'S PHYSICIAN
[redacted]

BIRTH/COLLECTION INFORMATION
Date Time
[redacted]

These results assume no transfusion prior to testing. Interpretations are based on clinical and demographic information provided.

TEST	CUTOFF	RESULT	INTERPRETATION
Phenylketonuria			
• Phenylalanine		81 µmol/L	
• Tyrosine		117 µmol/L	
• Phenylalanine/Tyrosine Ratio	≥ 1.50	.70	negative
Galactosemia			
• Galactose-1-uridyl transferase	≤ 50	262 enzyme units	negative
Primary Congenital Hypothyroidism			
• TSH	≥ 25.00	4.27 mIU/L	negative
Hemoglobinopathies			
• Hb Pattern		FA	negative

Hb Interpretation: *Usual hemoglobin pattern. These results assume no transfusion prior to testing and do not rule out the possibility of a thalassemia trait or rare hemoglobin variants.*

[redacted]

If you have questions regarding these results, please contact the Newborn Screening staff at STANFORD UNIVERSITY, (650) 812-0353.

Testing Laboratory: ALLIED MEDICAL LABORATORY 453 RAVENDALE DRIVE, STE B, MOUNTAIN VIEW, CA 94043
John Sherwin, Ph.D., Chief, Genetic Disease Laboratory Section

OFFICE USE ONLY: 335-94-013//21-2004-12 12/01/04 R356 XX 1 11 - 89

Patient: [redacted]

Michigan Department of Community Health
Bureau of Laboratories
3350 N Martin Luther King Jr Blvd
PO Box 30689
Lansing, MI 48909

Reported [redacted]
Printed

NEWBORN SCREENING
LABORATORY RESULTS

EW SPARROW HOSPITAL
LABORATORY SUPERVISOR
1215 E. MICHIGAN AVE.
LANSING, MI 48909

Kit Number:
Accession Number: [redacted]

Baby Name: [redacted]
Birth Date:
Collection Date: [redacted] Collection Age: 32 hours
Mother Name: [redacted]
Physician:
Submitter:

Gender:
Birth Facility: [redacted]
Specimen Type: FIRST
Medical Record: [redacted]
Phone:
Phone: [redacted]
Phone:

Fax:
Fax:

Disorder	Analyte	Patient Result	Expected Result	Interpretation	Comment
CAH	17-OHP	31 ng/mL	< 60 ng/mL	Normal	
Hypothyroidism	TSH	9 uIU/mL	* Varies with Age	Normal	
Galactosemia	GALT	11.9 U/gHb	> 3.1 U/gHb	Normal	
Maple Syrup Urine Disease	Leucine	129 umol/L	< 300 umol/L	Normal	
Phenylketonuria	Phenylalanine	67 umol/L	< 134 umol/L	Normal	
MCAD	Acylcarnitine(s)	Normal Profile	Normal Profile	Normal	
Hemoglobinopathy	Hemoglobin	Normal Pattern	Normal Pattern	Negative	
Biotinidase Deficiency	Biotinidase	Normal Activity	Normal Activity	Normal	
Homocystinuria	Methionine	37 umol/L	< 87 umol/L	Normal	
Citrullinemia	Citrulline	16 umol/L	< 54 umol/L	Normal	
Argininosuccinic Aciduria	Citrulline	16 umol/L	< 54 umol/L	Normal	

* Age, Expected Result (uIU/mL): <24h not defined; 24-36h, < 33; 37h-6d, < 25; 7-31d, < 13; >31d <= 10

Recommended Actions:

None

The laboratory values in this report represent screening test results and are intended to identify infants at risk for selected disorders and in need of more definitive testing. "Normal" refers to the analyte measured. The above results should be correlated clinically with consideration of age at the time of collection, nutrition, birth weight, prematurity, health status, and treatments. Rescreening of infants that were initially tested before 24 hrs of age is recommended, if warranted clinically. Performance characteristics were determined by MDCH.

Physician Forward Copy

[redacted] [redacted] **Patient Report** [redacted]

Date Collected: **05/30/2023** Date Received: **05/30/2023** Date Reported: **06/01/2023** Fasting: **No**

Ordered Items: **Hgb Solubility; Venipuncture**

Date Collected: **05/30/2023**

Hgb Solubility

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
Hemoglobin (Hgb) Solubility[01]	Negative Since a variety of conditions and other abnormal hemoglobins in addition to Hemoglobin S may give false-positive results, positive Hemoglobin Solubility tests should be confirmed by hemoglobin fractionation testing.			Negative

Disclaimer
The Previous Result is listed for the most recent test performed by Labcorp in the past 5 years where there is sufficient patient demographic data to match the result to the patient. Results from certain tests are excluded from the Previous Result display.

Icon Legend
⚠ Out of Reference Range ▩ Critical or Alert

Performing Labs

[redacted]

Patient Details

[redacted]

Physician Details

[redacted]

Specimen Details

[redacted]

Date Collected: **05/30/2023 0735 Local**
Date Received: **05/30/2023 0000 ET**
Date Entered: **05/30/2023 0904 ET**
Date Reported: **06/01/2023 1706 ET**

THIS IS AN EXAMPLE OF AN ACCEPTABLE SICKLE CELL SOLUBILITY TEST FROM A PRIVATE LAB.

[redacted]

This is how the result of a Hemoglobin Electrophoresis or High Performance Liquid Chromatography (HPLC) test will look.

MUSC Health
Medical University of South Carolina

Patient Demographics

Patient Name	Legal Sex	DOB	Address	Phone
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

HEMOGLOBIN VARIANTS: Patient Communication

Released Seen

Results

HEMOGLOBIN VARIANTS (Order 303650338)

HEMOGLOBIN VARIANTS

Order: 303650338

Status: Final result Visible to patient: Yes (seen) Next appt: None

Dx: Encounter for sickle-cell screening

Component Ref Range & Units	6 mo ago
Hemoglobin A2 1.5 - 4.0 %	2.9
Hemoglobin, Fetal 0.1 - 2.0 %	<1.0
Hemoglobin A 94.0 - 98.4 %	96.6
Hemoglobin S	
Hemoglobin C	
Other Hemoglobin Variant	
EHGB Interpretation	Normal

Comment: Normal hemoglobin evaluation. No evidence of abnormal hemoglobin.

Resulting Agency MUSC LAB

Narrative

[redacted]

INTERPRETIVE DATA: I certify that I have reviewed the testing performed on this patient and have rendered the above diagnosis.

[redacted]

Disclaimer: This test method has not been approved by the U.S. Food and Drug Administration. The performance characteristics of this method were validated by the Special Chemistry Laboratory of the Medical University of

[redacted]