

Required Forms Checklist
Virginia Tech Corps of Cadets
Class of 2012

- 1.) **Schedule a medical examination/check-up.**
(If you have passed a DODMERB physical, skip to Step 4.)
This physical is separate from the immunization forms you are required to return to the Virginia Tech Schiffert Health Center! Please DO NOT mail us your immunizations forms, they go to Schiffert Health Center. This physical is also separate from any physical your ROTC unit may require.
- 2.) **Before your exam, fill in the information on Form 3: Report of Medical History.**
- 3.) **During your examination/check-up, have your physician complete and sign Forms 3 & 4.**
- 4.) **Make a photo copy of the front *and* back of your parents' health insurance card or HMO card that you (the cadet) are covered under.**
- 5.) **Go online and complete your Personal Data & Student Profile here:**

<https://survey.vt.edu/survey/entry.jsp?id=1208964975174>
- 6.) **No later than 16 June 2008**, complete the enclosed forms and return them to:

Virginia Tech
Office of the Commandant
143 Brodie Hall (0213)
Blacksburg, VA 24061

Check the forms off below to ensure you have included them all.

_____ **Form 1:** Acknowledgement of the Board of Visitors'
Cadet Participation Policy

_____ **Form 2:** Medical Care Authorization

_____ **Form 3:** Report of Medical History

_____ **Form 4:** Report of Medical Examination

_____ OR {
DODMERB
Qualification
Letter

* A copy of the letter from DODMERB indicating you've passed, may be returned in lieu of Forms 3 & 4.

FORM 1
MEDICAL CARE AUTHORIZATION

We are providing this form in an effort to provide the best quality medical care in the event a new cadet becomes sick or injured. We intend to involve the parents or legal guardians in any significant medical treatment but medical care may be required when a parent or guardian is not available. **Please sign and return the statement below, along with your other new cadet forms by 16 June 2008.**

Please include with this form a copy (front and back) of the health insurance card or HMO card that your son/daughter is covered under. This is a precaution to prevent unnecessary medical expenses in the event that your son/daughter needs to seek medical treatment.

I hereby grant permission for my son/daughter to receive medical attention while participating in the New Cadet Training Program and related activities should the need arise. This includes medical attention in cases of emergencies.

New Cadet Name: _____
(print name)

Student ID Number: _____

Parent or Guardian Name: _____
(print name)

Parent or Guardian Signature: _____

Date: _____

FORM 2
BOARD OF VISITORS'
CADET PARTICIPATION POLICY

Please sign this statement indicating that you have read and understand the Virginia Tech Board of Visitors' policy regarding cadet participation in the Corps of Cadets and the consequences of withdrawing from the Corps of Cadets prior to the last day to drop classes.

1. Pursuant to the student life policy established and directed by the Board of Visitors of Virginia Tech, all first semester students electing participation in the Virginia Tech Corps of Cadets are required to maintain their student status as a cadet and may not withdraw from the Cadet Regiment and change to civilian student status until **the last day to drop a class without penalty** (after approximately six weeks of class).
2. Once in-processed, first semester students who desire to withdraw from the Cadet Regiment prior the "last day to drop a class without penalty" must withdraw from the University and re-enroll at Virginia Tech the next semester.
3. I understand and acknowledge the Board of Visitors' cadet participation and withdrawal policy and accept enrollment into the Corps of Cadets.

Signed Name

Student ID Number

Printed Name

Date

INFORMATION SHARING WAIVER

I grant permission for the Commandant of Cadets and his staff to discuss Corps matters with my parents/legal guardians.

_____ Yes

_____ No

Signature: _____

Date: _____

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
		15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc. B. Inability to perform certain motions. C. Inability to assume certain positions. D. Other medical reasons (If yes, give reasons.)	
		16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)	
		17. Have you ever been denied life insurance? (If yes, state reason and give details.)	
		18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)	
		19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	
		20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	
		21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	
		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)	
		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	
		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)	
<p>I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.</p>			
TYPED OR PRINTED NAME OF EXAMINEE		SIGNATURE	
<p>NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY." 25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)</p>			
TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER		DATE	SIGNATURE
			NUMBER OF ATTACHED SHEETS

FORM 4
REPORT OF MEDICAL EXAMINATION

Last Name _____ First Name _____ Middle Name _____ Age _____

INSTRUCTION FOR MEDICAL EXAMINER

The standard for acceptance into the Virginia Tech Corps of Cadets is the ability to fully participate in training activities. This includes strenuous physical exercise and activities which may occur in a hot and humid environment. Defects that have the potential to result in illness or injury brought on by physical exercise should be identified and other condition(s) which could interfere with full and unrestricted participation need to be listed and evaluated. Conditions that will or are likely to require treatment, particularly unresolved injuries and recurrent illnesses also must be listed. **It is imperative that ALL the listed tests be done and all questions answered.**

Height: Ft. _____ In. _____ Weight: _____ lbs. Obese: Yes _____ No _____ Pulse: _____

Blood Pressure _____/_____

Eyes, ears, nose: _____

Vision: Wear glasses: Yes _____ No _____ Wears contacts: Yes _____ No _____

Lungs _____ Heart _____ Abdomen _____ Genitalia _____ Hernia _____

Spine _____

Orthopedic oriented examination (evaluation of conditions that may limit involvement in physical activities --i.e., sports, physical training, etc.):

Body Symmetry: _____ Cervical Spine Motion: _____ Upper Body Flexibility: _____

Lower Body Flexibility: _____ Knee Stability: _____ Other: _____

Remarks: _____

It is the opinion of the medical examiner that this examinee has _____ / does not have _____ a communicable (or other) disease, injury, or other condition that will restrict his/her participation in the Corps of Cadets Program. (List any disqualifying defects above.)

Signature

Typed or printed name of medical examiner

Date