USCGA

Medical History and Clearance Form

AIM Coordinator (tw-c)

U.S. Coast Guard Academy
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Privacy Act Statement. In accordance with 5 USC 552a(e)(3), the following information is provided to you when supplying personal information to the USCG. (1) Authority which authorizes the solicitation of the information: 14 USC 182. (2) The Principal Purpose for this information is to ensure that an accurate medical history is collected (and utilized) for all applicants during the USCGA AIM Program. (3) Routine uses which may be made of the information: As background on applicants for the selection process; to contact the applicant; to determine if there are existing USCG records on the individual; in performance of the duties of officials and employees of the USCG in managing the AIM Program and making AIM appointments. (4) Disclosure of the information is voluntary, but the applicant will not be considered further for the AIM Program if the information is not provided.

Student's Name:_____ ☐ Male ☐ Female _____

Last First M.I. Gender Date of Birth (i.e. 01 OCT 2003)

AIM Session (1, 2, 3): _____

Each question (***on both sides of this sheet***) must be completely answered. Sections I and II must be filled out in their entirety by the AIM student and a parent or legal guardian; Section III must be filled out in its entirety by a licensed Physician (MD or DO) or a Physician's Assistant or Registered Nurse Practitioner at said Physician's direction.

SECTION I

AUTHORIZATION FOR MEDICAL TREATMENT

I (we), the undersigned, am (are) the parent(s) and/or legal guardian(s) of the above named student, a minor, being under the age of eighteen (18) years. I (we) have specifically granted my (our) said child permission to attend the U.S. Coast Guard Academy AIM Program to be held at the U.S. Coast Guard Academy in New London, Connecticut in July 2022.

To the best of my (our) knowledge and belief, my (our) said child has no mental or physical defects, diseases or impairments, and during such program he/she may engage in all physical activities, including drills, exercises, and sports. Without limiting the generality of the foregoing, I (we) specifically verify that the medical history information previously submitted with said child's AIM application is complete and accurate, and that said information is unchanged as of the date we sign this authorization. We agree to notify the Admissions Office of any change therein that occurs from now until said child's arrival at the U. S. Coast Guard Academy for AIM 2022.

In the event my (our) said child should become ill or injured while participating in this program, including the period of time while my (our) said child is traveling from his/her place of residence to the U.S. Coast Guard Academy, while at the U.S. Coast Guard Academy, and returning from the U.S. Coast Guard Academy to his/her place or residence, I (we) hereby authorize all medical personnel, including but not limited to physicians, physician assistants, nurse practitioners, athletic trainers and other health personnel working at the U.S. Coast Guard Academy's direction to administer drugs, medication (prescription or over-the-counter), blood, and medical treatment, including emergency first aid and surgery which, in the judgment of any of the above, is necessary or desirable to protect the life, health, well-being, or safety of said child. All decisions concerning medical treatment of all types may be made by such medical personnel. Except for first aid, immediate emergency treatment, and ongoing evaluation and treatments by licensed athletic trainers, all AIM students will be transported to local emergency rooms, physician offices, or walk-in clinics at the expense of the parent or guardian for medical treatment. Students will not be treated on base or by Coast Guard personnel, except as stated above.

I (we) further agree that any and all medical treatment deemed to be necessary and appropriate, in the opinion of such medical personnel, may be undertaken without notification to me (us). I (we) further represent and agree that, in the exercise of the discretion in selection of medical facilities, medical personnel, the U.S. Coast Guard, the U.S. Coast Guard Partners and the officers, members, personnel and employees thereof, are hereby released, indemnified and held harmless from any loss of liability they, or any of them may incur or suffer by virtue of acts or omissions in pursuance of the premises herein set forth. I (we) further agree to reimburse the said U.S. Coast Guard, U.S. Coast Guard Partners and the officers, members, personnel and employees thereof, for any and all costs and expenses they, or any of them, may incur, in connection with such medical treatment.

I (we) agree that a photocopy of this original signed form shall have the same validity as said original.

_____

PARENT/GUARDIAN SIGNATURE DATE

SECTION II

EMERGENCY CONTACT INFORMATION AND MEDICAL HISTORY

PARENT/GUARDIAN HOME MAILING ADDRESS:

_____

_____

_____

HOME TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

ALL CELL PHONE NUMBERS (WITH NAMES): _____

ALL WORK TELEPHONE NUMBERS (WITH NAMES): _____

IF MEDICAL PERSONNEL ARE UNABLE TO CONTACT PARENT/GUARDIAN, ANY OF THESE OTHER PERSONS ARE AUTHORIZED TO SPEAK AND ACT ON OUR BEHALF:

NAMES	RELATIONSHIP	ALL PHONE NUMBERS

MEDICAL INSURANCE COVERING CHILD (STUDENTS MUST HAVE MEDICAL INSURANCE TO PARTICIPATE IN AIM):

COMPANY	POLICY #

STUDENT'S MEDICATION, FOOD, OR OTHER ALLERGIES*:*

_____

_____

(WRITE "NONE" IF THAT IS THE CASE)

1. **Do you have any limitations or disabilities that may impact your participation in daily physical & mental activity of the AIM program?** **Yes** ☐ **No** ☐
   - If Yes, give details _____
2. **Do you have, or have you ever had, an adverse reaction to any medicine, drug, stinging insect, food product, or other substance or environmental condition?** **Yes** ☐ **No** ☐
   - If Yes, what was the reaction to? _____
   - Was the reaction life-threatening, (for example, difficulty breathing, obstructed air-way, shock, cardiac trouble) i.e., a true allergy, OR was it less severe (for example, rash, nausea, itching) _____
3. **In the last two years, has a doctor or other medical professional ever denied or restricted your participation in sports for more than one day?** **Yes** ☐ **No** ☐
   - If Yes, when and why? _____
4. **During or after exercise, have you ever**
   - **A. Passed out or nearly passed out?** **Yes** ☐ **No** ☐
   - **B. Had pressure in your chest?** **Yes** ☐ **No** ☐
   - **C. Had your heart skip beats?** **Yes** ☐ **No** ☐
   - If you answered Yes to A, B, or C, please describe what happened _____

     _____

5. **Do you cough, wheeze, or have difficulty breathing during or after exercise?** **Yes** ☐ **No** ☐
   - If Yes, give details _____
6. **Have you ever used an inhaler or taken asthma medication after the age of 13?** **Yes** ☐ **No** ☐
   - If Yes, give details, including when _____
7. **Within the past two years, have you been hospitalized, prescribed medication, placed on a special diet, or given any limitations of physical or other activity?** **Yes** ☐ **No** ☐
   - If Yes, what, when and why? _____

   _____
8. **Are you *currently* taking any prescription or over-the-counter medications?** **Yes** ☐ **No** ☐
   - If Yes, what and how often? _____
9. **Have you ever had surgery?** **Yes** ☐ **No** ☐
   - If yes, what problem, what procedure, and when performed? _____
10. **In the past year have you had a head injury that was diagnosed as a concussion, or that caused you to lose consciousness, to have memory loss, or to have headaches for more than two consecutive days?** **Yes** ☐ **No** ☐
    - If yes, give details, including when _____
11. **Have you ever had a seizure after the age of 5?** **Yes** ☐ **No** ☐
    - If yes, give details, including when _____
12. **Any medical conditions not listed? (Cardiac, Neurological, Respiratory, or Psychological?** **Yes** ☐ **No** ☐
    - If yes, give details, including when _____
13. **Are you vaccinated against COVID-19?** **Yes** ☐ **No** ☐
    - If yes, which vaccination did you receive?_____
    - If yes, date of first and second dose (if received)_____
    - If no, provide the estimated date of first dose_____

As a reminder, students who desire to attend one of the in-person AIM sessions must be fully vaccinated by CDC standards prior to arrival on campus.* **Please submit a copy of your COVID-19 Vaccination Card with this form.
** In addition, **please submit a copy of your Medical Insurance Card with this form**

DATE SIGNED:_____. We, the undersigned AIM student and parent/guardian, each state under oath that to the best of our knowledge our answers to the above medical questions are complete and accurate. We each agree to notify the Admissions Office of any change in the history or of any medical treatment received by the student since the date of our signing this form AND since the date of the physician's examination described below.

_____ _____

Printed Name of AIM Student | Printed Name of Parent/Guardian

_____ _____

Signature of AIM Student | Signature of Parent/Guardian

Privacy Act Statement

Authority: 5 U.S.C. § 301; 14 U.S.C. § 93. Commandant; general powers; and 14 U.S.C. § 182

Purpose: To collect information used for students accepted to and attending the summer Academy Introduction Mission (AIM) program the ability to receive medical clearance from their primary care physician and for parents to release liability for personal injury while their son or daughter attends the AIM program.

Routine Uses: This information will be used as a basis for establishing eligibility and may be disclosed externally as a "routine use" pursuant to DHS/USCG-011, Military Personnel Health Records, 73 Federal Register 77773 (December 19, 2008) and DHS/USCG-014, Military Pay and Personnel, 76 Federal Register 66933 (October 28, 2011) .

Disclosure: Furnishing this information is voluntary; however, failure to provide this information may impact your eligibility for Academy enrollment. .

SECTION III

PHYSICIAN CLEARANCE

I certify that:

1) I am an MD or DO (or a Physician's Assistant or Registered Nurse Practitioner under MD or DO direction) duly licensed to practice by the State or Commonwealth of_____;
2) I understand that the student will be participating in daily vigorous physical and mental activity for a one week period in Connecticut in July, 2022;
3) I have on this date reviewed the medical history of the named AIM student furnished above and on the reverse side.
4) I represent that either "A" or "B" below (please check one or the other) is true:

   ☐ A. I physically examined said student today; OR

   ☐ B. I examined said student on or after August 1, 2021; AND

5) based on said review, examination results, and understanding, this student is cleared to participate in said activity with: (check one)

   ☐ No **physical, mental** or **dietary** restrictions

   ☐ The following restrictions: **(provide specifics below)**

Examiner's printed name and title: _____

Examiner's full address, telephone number, and fax number:

_____

_____

_____

_____

_____

Examiner's signature:_____ Examiner's Office stamp:

Date signed: _____

EMAIL THIS COMPLETED FORM TO AIM@USCGA.EDU BY June 15th, 2022!

OMB Control No.: 1625-0121
Expiration Date: 05/31/2022