YOUNG MARINES OF THE MARINE CORPS LEAGUE
WASHINGTON DC

Young Marines
Health History and Physician's Report
PLEASE PRINT (Update Annually)

Last Name _____First Name _____Middle Initial_____

Age _____ Date of Birth ___/____/____Social Security Number_____

Home Street Address _____ City _____ State___ Zip Code _____

Parent/Guardian Name _____ Relationship _____

Home Telephone Number (____)_____ Work Telephone Number (____)_____

Mobile Number (____)_____ Pager Number (____)_____

Physician's Name _____ Date of Last Visit _____

Dentist's Name _____ Date of Last Visit _____

HEALTH HISTORY (Completed by Parent/Legal Guardian)

The Subject Young Marine:	***Yes**	**No**	**Remarks ("Yes" require remarks)**
Wears Eye Glasses			
Wear Contact Lenses			
Is on a restricted diet			
Wear a hearing aid			
Visted the Dentist in the last 6 months			
Is under a doctors care			
Is on prescription medication			
*Has Allergies Food//Medication//Environmental			
Has heart murmur Suffered Rheumatic Fever Had a family member under age 50 die of a heart problem			
Suffers one or more of the following conditions: Seizures Diabetes Asthma Arthritis			
Have a history of head injury			
Been hospitalized within the past year			
Received a Tetanus Booster and Date			

I certify to the above to be complete, correct, and true to the best of my knowledge.

Parent/Legal Guardian _____ Date _____

(YMFORM 14)

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PHYSICAL EXAMINATION (Must be completed by a Physician, PAC, or CRN)
(A current school or sports physical may substitute, if done during the current school year. A photocopy must be on file on the next page of the YMRB.)

Height _____ Weight _____ BP _____ Vision Screen _____

Hearing _____ Lungs _____

Heart Rate _____ Rhythm _____ Hernia _____

Neurological Examination _____

Remarks:
_____
_____
_____
_____

Are there any restrictions or accommodations needed for the following activities?

Activities	Yes	No	Remarks ("Yes" require remarks)
Competitive Sports			
Physical Training			
Swimming			
Classroom			
Other			

I certify that _____ is/is not physically and medically fit to participate in the Young
(Child's name)
Marines.

Please provide additional remarks or instructions, if participation in the Young Marines is conditional due to any medical conditions not provided in the remarks above.
_____
_____
_____
_____
_____
_____
_____
_____
_____

Examiner's Signature _____ Date of Exam _____

Print Examiner's Name_____ Title _____

Office Address _____

City _____State _____ Zip Code _____

Office Telephone Number (____)_____

(YMFORM 14)