Texas A&M Maritime Academy
Corps of Cadets
Pre-participation Release Form

To facilitate your arrival into the Corps of Cadets, the Office of the Commandant requires you to provide your health and medical history to verify you are medically able to meet the requirements of being a cadet and/or identify to our staff any permanent limitations.

This form will be completed in addition to any university health form, ROTC scholarship physical forms, or USCG Application for Medical Certificate you may be required to complete.

Bring your completed form to Orientation Week check-in/arrival.

- Forms are considered complete once they have been signed by a physician, physician assistant or nurse practitioner.
- You are required to bring a copy of the completed form with you to Fall Orientation Week/Spring Orientation Week check in.
- Failure to complete the form and/or return it at O-Week check in will result in an exam being conducted by a local physician at your expense.
- No new cadet will be allowed to participate in any physical exercise or physical training until a current, completed form is on file with the Office of the Commandant.

Email corpsinfo@tamug.edu with any questions.

Page 1 to be completed by cadet / parent

CORPS OF CADETS PREPARTICIPATION PHYSICAL EVALUATION – MEDICAL HISTORY

University Identification Number (UIN) :____/____/____ Phone:_____Email:_____
Name:_____Age:_____ Sex: M F
Home Address:_____
Street City State Zip Code
Health / Accident Insurance Company_____ Policy No. _____
ATTACH A PHOTO COPY OF BOTH SIDES OF INSURANCE CARD, IF NO INSURANCE STATE ' NONE'
In Case of Emergency, notify
Name _____ Relationship _____
Address _____
Phone _____ Alternative Phone # _____

The Cadet lifestyle is a highly structured program that is both **PHYSICALLY** and **MENTALLY** rigorous, designed to safely challenge cadets. Examples of typical activities are listed below.

WEEKDAYS: 0530 Rise. 2300 lights out. Physical Training and Unit Activities are conducted early morning and late afternoon.

Physical Training (PT) is designed to attain and maintain an acceptable level of fitness for each cadet. Physically able cadets are expected to be able to execute push-ups, sit-ups and a 1.5-mile run. In addition, cadets that have a military contract/scholarship are required to pass the physical requirements for their branch of service, which is more difficult than the Corps recommendations.

Unit organized activities include close order drill, unit formation runs, functional fitness workouts, 2 to 5 mile ability group runs, organized sports, and obstacle/stamina course events and other strenuous activities. Cadets must be physically fit or willing to work toward becoming fit.

I certify I have reviewed the list of typical activities and feel I (my child) am (is) mentally and physically healthy and therefore capable of undertaking these activities. I also agree any medical concerns as noted by the physician on the following pages of this pre-participation physical evaluation – medical history can be disclosed to individuals within the Texas A&M Maritime Academy, Commandant's Staff and the Corps of Cadets. I (My child) fully assume(s) the responsibility to immediately notify the Texas A&M Maritime Academy, Commandant's Staff and the Corps of Cadets organization of any updates if my (my child's) medical condition changes for any reason. I (My child) further consent to medical treatment for minor injuries incurred during physical exercise as long as performed by qualified medical personnel.

Cadet's Signature: _____ Date: _____

Parent's Signature (if Cadet is under age 18): _____ Date: _____

Updated: 25 Nov 2025

Pages 2 & 3 to be completed by a physician

TEXAS A&M MARITIME ACADEMY CORPS OF CADETS

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

I certify that I have reviewed the lifestyle and activities listed on the previous page.

In order for the staff to be adequately aware and plan accordingly for a specific level of cadet participation, all medical conditions that may impact a cadet's involvement in corps activities, as well as prolonged standing and marching, should be identified and listed below. List any medical concerns (i.e. limiting medical, psychological, or emotional conditions that require ongoing treatment and/or medication.)

Existing Medical Concerns or Conditions limiting participation in Corps Activities (Please print or type):
**More space to elaborate conditions continued on next page.

Yes	No	Condition	Diagnosed Date	Comments	Phys. Signature
		Asthma / Last Attack _____ Inhaler Use: YES / NO			
		High Blood Pressure			
		Heart Disease/Family History of H.D.			
		Other Cardiac Disorder			
		Fainting Spells			
		Stroke			
		Head Trauma / Concussion			
		Seizure / Last Seizure _____			
		Lung / Respiratory Disease			
		Ear / Sinus Problems			
		Menstrual Problems (Females)			
		Bleeding Disorders			
		Sickle Cell Disease			
		Kidney Disease			
		Thyroid Disease			
		Diabetes (Type 1 / Type 2)			
		Other Endocrine Disorder			
		Abdominal / Digestive Problems			
		Sleep Disorder			
		Psychiatric / Psychological Disorder			
		ADHD			
		Spectrum Disorder			
		Vision Disorder			
		Hearing Disorder			
		Skin Disorder			
		Musculoskeletal Disorder			
		Surgery: _____ _____	Procedure Date:		

Pages 2 & 3 to be completed by a physician

How does the cadet rate their current fitness level within the last year? Mild____ Moderate____ Elite ____

(Mild: 0-1 >30-min workouts/week; Mod: 2-4 >30-min workouts/week; Elite: 5+ >30-min workouts/week)

Please list any allergies with which the cadet has been diagnosed:

_____

_____

Does the diagnosed allergy require the cadet to carry any EpiPen? YES / NO

Other than an EpiPen, does the cadet require the use of any medications? Please Initial

_____ Yes (If yes, please list below:)

_____ No, the cadet does not require or take any prescribed medications.

Medication Name	Dosage	Frequency	Related medical condition

Additional Comments (May be used to elaborate on issues identified on page 2)

_____

_____

_____

_____

CLEARANCE

☐ **Cleared**

☐ **Cleared after completing evaluation/rehabilitation for:**_____

_____

☐ **Not cleared for**: _____

Recommendations:_____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners

Examination forms signed by any other health care practitioner will not be accepted.

Physician Name (print/type) _____ Date of Examination: _____

Address: _____ Phone Number:_____

Signature: _____