

PRIVACY ADVISORY STATEMENT

NEW YORK NAVAL MILITIA

Health and Medical Personal Information

AUTHORITY FOR COLLECTION OF PERSONAL INFORMATION: Personal Privacy Protection Law of New York State; Privacy Act of 1974, 5 U.S. Code, sections 552-522a.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION: The requested information is mandatory for New York Naval Militia (NYNM) members to insure that: (1) medical record information is accurate for the individual member; and (2) to document all active duty medical incidents in view of future rights and benefits. If the requested information is not furnished, the NYNM member will not be considered for assignment for routine or emergency state active duty. If a NYNM member currently serving on routine or emergency state active duty declines to provide the requested information, the NYNM member's assignment to routine or emergency state active duty may be terminated.

ROUTINE USES: This all inclusive Privacy Act Statement will apply to all requests for personal information made by the New York Naval Militia and applicable health care providers, or for medical treatment purposes. It will become part of your New York Naval Militia service record. The intended use is in order to maintain a rapid recall capability, emergency notification, and to facilitate and document your health care.

PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED: The primary use of this information is to identify NYNM members who are physically capable of conducting routine and/or arduous tasks that may arise during the performance of state active duty. This form provides you the advice required by the New York State Personal Privacy Act and the federal Privacy Act of 1974.

THIS FORM IS NOT A CONSENT FORM TO RELEASE PERSONAL INFORMATION PERTAINING TO YOU TO AGENCIES AND ENTITIES OUTSIDE OF THE NEW YORK STATE DIVISION OF MILITARY AND NAVAL AFFAIRS AND THE JOINT FORCES OF THE NEW YORK STATE ORGANIZED MILITIA.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

Signature of NYNM member

Date

Printed name and grade/rank of NYNM member

New York Naval Militia (NYNM)	REPORT OF MEDICAL HISTORY AUTHORIZATION, CONSENT AND RELEASE	FOR OFFICIAL USE ONLY NYNM Form 93
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NOTICE

The information requested below is required to provide the medical examiner an accurate history of illnesses and injuries that may affect the applicant's ability to perform the strenuous physical exercise and exposure to living and working environments that are a part of the New York Naval Militia. Also this information will be provided to medical examiners in case of injury or illness. **If taking medications at time of application, list in Block 6.**

THE INFORMATION YOU PROVIDE MUST BE ACCURATE AND COMPLETE. You are encouraged to consult your private medical provider regarding past illnesses.

1. UNIT INFORMATION

1a. Unit Name	1b. NYNM Region
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2. PERSONAL INFORMATION

2a. Last Name	2b. First Name	2c. MI	2d. Blank
2e. Age	2f. Date of Birth (DD MMM YY)	2g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	2h. Emergency Person Contact Name and Phone Number
2i. Home Address		2j. City	
2k. State	2l. Zip Code + 4	2m. Home Phone	2n. Date of Physical Examination (DD MMM YY)

3. MEDICAL HISTORY (Mark each item "YES" or "NO" Every item marked YES must be fully explained in block 6: explain treatment to return member to medically fit for duty)

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS:	YES	NO		YES	NO
3a. Tuberculosis or live with someone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	3m. Head injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>
3b. Chronic or recurrent abdominal or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	3n. Seizures, convulsions, epilepsy, or fits	<input type="checkbox"/>	<input type="checkbox"/>
3c. Asthma or breathing problems related to exercise, pollen, etc.	<input type="checkbox"/>	<input type="checkbox"/>	3o. Car, train, sea, and/or air sickness	<input type="checkbox"/>	<input type="checkbox"/>
3d. Been prescribed or use an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	3p. A period of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
3e. Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	3q. Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>
3f. Loss of hearing or wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	3r. Received counseling for emotional or behavior disorder	<input type="checkbox"/>	<input type="checkbox"/>
3g. Impaired use of arms, legs, hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	3s. Eating disorder (bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>
3h. Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	3t. Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
3i. Broken bones(s) (cracked or fractured)	<input type="checkbox"/>	<input type="checkbox"/>	3u. Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
3j. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	3v. Been hospitalized (<i>if yes, why, when, where</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3k. Anemia (including sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>	3w. Any illness or injury not mentioned above (<i>if yes, explain</i>)	<input type="checkbox"/>	<input type="checkbox"/>
3l. Dizziness or fainting spells (including after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	3x. Advised to avoid certain physical activities (<i>if yes, explain</i>)	<input type="checkbox"/>	<input type="checkbox"/>

4. IMMUNIZATION RECORDS

IMMUNIZATIONS			
	Month/Year Given		Month/Year Given
Tetanus	____/____	Mumps	____/____
Diphtheria	____/____	Rubella	____/____
Pertussis	____/____	Polio	____/____
Measles	____/____	Chicken Pox	____/____
Small Pox	____/____	Influenza	____/____
		Tdap	____/____
		Hepatitis A	____/____
		Hepatitis B	____/____
		TB/PPD	____/____
		Anthrax	____/____

PREVIOUS EDITIONS ARE OBSOLETE

REPORT OF MEDICAL HISTORY

NYNM Form 93

5. ALLERGIES (Mark each item "YES" or "NO" Every item marked yes must be fully explained in block 5i)

DO YOU NOW HAVE ANY OF THE FOLLOWING ALLERGIES:	YES	NO		YES	NO
5a. Bee or Wasp Sting	<input type="checkbox"/>	<input type="checkbox"/>	5e. Latex	<input type="checkbox"/>	<input type="checkbox"/>
5b. Hay Fever or seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	5f. Any drug, E-mycin antibiotic, or sulfa allergies, list in Block 5i	<input type="checkbox"/>	<input type="checkbox"/>
5c. Insect Bites	<input type="checkbox"/>	<input type="checkbox"/>	5g. Other Allergies, list in Block 6	<input type="checkbox"/>	<input type="checkbox"/>
5d. Iodine/seafood	<input type="checkbox"/>	<input type="checkbox"/>	5h. Food allergies, list in Block 6	<input type="checkbox"/>	<input type="checkbox"/>

5i. Describe the allergic reaction and what condition occurs:

6. Remarks (Please include comments as required by Block 3. Also provide any other medical history that you or your physician deems important.)

List all current medications, including over-the-counter medications, vitamins, and supplements;

Social History:

Tobacco Use: Number of packs or dips per day: _____

Alcohol Use: Number of drinks per week (on average): _____

List all current medical restrictions:

Have there been any significant changes in your health since your last medical examination: NO YES. If YES, please describe:

7. AUTHORIZATION AND RELEASE

I certify that to the best of my knowledge the information provided is true and accurate and that I have disclosed all pertinent medical history.

8a. Member Name (Type or Print)

8b. Signature

8c. Date (DD MMM YY)