FT LEE
AIT SELF-CARE PROGRAM

I am aware that I am participating in a **SELF-CARE** program. I understand that to properly perform **SELF-CARE** and safely treat **ANY** symptom(s) or condition(s) that I may have during AIT, I *must* follow the Healthwise Handbook decision guidelines. I also understand that I am responsible for carefully following the directions for use of any medication received through this program. I verify that I have read the Healthwise Handbook decision guide and perform all recommendations provided therein. I also verify that I am requesting treatment option(s)

_____ _____-___-_____ _____/_____/_____ _____

Name (Last, First, MI) (SSN) DOB (Day/Month/Year) Today's Date

_____ Male / Female _____.___ _____

Unit Temp Known Drug Allergies

_____ _____

Component Rank Signature: _____

Instructions: After reading the SELF CARE decision guide and identifying the proper symptom(s) / condition(s) find the corresponding treatment option(s) on the list below. Circle the symptom(s) / condition(s) -OR- the treatment option(s). Request treatment option(s) from Kenner Army Health Clinic's BAS Pharmacy. If you have been to self care for this before consult one of the Medics at the BAS to find out if Self care protocol is the treatment you need, or if you need to see a health care provider. If you have had the symptom(s) / condition(s) for more than a week consult a Medic to see if you need to see a health care provider.

Signs/Symptoms	Medication Options
Acne	Benzoyl Peroxide 5% Gel
Allergies/Hay Fever	Actifed (Anti-Histamine)
Athlete's Foot	Miconizole Nitrate (Anti-Fungal Cream)
Blisters	Bacitracin Anti/Biotic Ointment
Cough — Productive (With Phlegm)	Robitussin
Cut or Scrape	Bacitracin Anti/Biotic Ointment
Diarrhea	Pepto Bismol
Earache	Tylenol
Headache	Tylenol
Muscle Pain/Inflammation	Motrin (200mg)
Insect Bite / Skin irritation	Cortaid Cream (Hydrocortisone)
Jock Itch	Miconizole Nitrate (Anti-Fungal Cream)
Ringworm	Miconizole Nitrate (Anti-Fungal Cream)
Nasal Congestion	Saline Nasal Spray
Sore Throat	Cepacol (Throat Lozenges)
Upset Stomach	Pepto Bismol
Vaginitis	Mycelex (Vaginal Cream)

FORT LEE SICK CALL SLIP

TO BE COMPLETED BY UNIT

ALL SERVICE MEMBERS MUST WEAR SHORTS

Name: (Last, First)		Date: First Visit at TMC: **YES** **NO**
SSN:	Rank:	AIT Graduation Date:
DOB: (ddmmmyy)	Age:	PT Test: Pass Fail Not Taken
Gender: M F	Company: **Hold**: over or under	End of Cycle Certified: No Yes
Component: RA ER NG USMC AF USN		Bulk Fuel Food Svcs Airborne ORD

Reason for Visit: (i.e. symptoms, injury location, duration, Doctor seen ~ must be provided)

CO/1SG/DS Signature:	Company Phone:

DISCHARGE INSTRUCTIONS

TO BE COMPLETED BY MEDICAL PERSONNEL

Limitation/Recommendation NOT To Exceed 30 days

☐ **SERVICE MEMBER WILL RETURN TO FULL DUTY**	☐ **SERVICE MEMBER TO FOLLOW PROFILE BELOW**
☐ **SERVICE MEMBER SHOULD DO THE FOLLOWING, AS DIRECTED:**	☐ **SERVICE MEMBER WILL NOT DO THE FOLLOWING:**
☐ Modified Sit Ups _____ ☐ Modified Push Ups_____ ☐ Walk at own pace & distance_____ ☐ Run at own pace & distance_____ ☐ Wear Running Shoes ☐ Apply ice _____ times daily ☐ Upper body stretching exercises ☐ Lower body stretching exercises ☐ Stationary Bike (Gym PT) ☐ Elliptical Machine (Gym PT) ☐ Rehab exercises (see attached sheet) ☐ Pool PT Days/Time:_____ ☐ Crutches / Brace_____ ☐ Gargle with warm salty water	☐ Run ☐ March ☐ Jump ☐ Sit ups ☐ Push ups ☐ Lower Body PT ☐ Upper Body PT ☐ Lift/Carry over_____ lbs. ☐ Stand over_____ minutes ☐ Wear Kevlar ☐ Wear Ruck Sack ☐ Prepare/Serve Food ☐ **Medication/Condition may place service member in higher risk for heat injury for _____ days!**

Attention!! BEDREST will never exceed 3 days (Call 734-6093 with question regarding bedrest): **Yes** **No**

Start:_____ End:_____

Return to _____ on _____ at _____ For Re-evaluation

PROFILE VALID THRU:	**Re-evaluate at _____** **On _____ at _____am/pm**

REMARKS:

Prescriptions given: Yes No

Discharge Time from TMC:_____ Medical Staff Stamp:

_____ _____ **Medic/Nurse Signature** **Duty Phone**	_____ _____ **Provider Signature** **Duty Phone**

CELL PHONES ARE PROHIBITED IN OR AROUND THE TMC

INDIVIDUAL SICK SLIP

☐ ILLNESS ☐ INJURY

DATE

LAST NAME-FIRST NAME-MIDDLE INITIAL OF PATIENT

SERVICE NUMBER/SSN | GRADE/RATE

ORGANIZATION AND STATION
Troop Medical Clinic
Bldg 3219
Fort Lee, VA 23801

UNIT COMMANDER'S SECTION

IN LINE OF DUTY

REMARKS

SIGNATURE OF UNIT COMMANDER

MEDICAL OFFICER'S SECTION

IN LINE OF DUTY

DISPOSITION OF PATIENT ☐ DUTY ☐ QUARTERS ☐ SICK BAY ☐ HOSPITAL ☐ NOT EXAMINED ☐ OTHER *(Specify)*:

REMARKS
Shave every _____days keeping beard trimmed to 1/8th".
Then shave every _____days, using hot towels before and after shaving x2 weeks. apply Cleocin- Tx2 times per day to affected area.
Return to BAS if further profile is needed.

SIGNATURE OF MEDICAL OFFICER

DD FORM 689, MAR 1963 PREVIOUS EDITIONS ARE OBSOLETE. APD PE v2.00