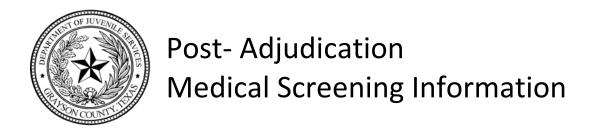


PHYSICAL EVALUATION Must be signed by MD, DO, PA or NP

Date:

Name:	Age:	_ Date:			
Height:	Weight:	BP:	/ Pulse:		
Vision: R 20/ L 20/	_ Corrected: Y	N	Pupils:	·	
Immunization Reviewed & Current:	Y N	TB Test Ad	ministered (Date):		
TB Test Read (Must be read within 48-72 hrs	s.) Date:	Time:	Results: Pos	Neg	
	Normal		Abnormal F	Abnormal Findings	
Cardiopulmonary			, 13.1.011113.1		
Heart					
Lungs					
Tanner Stage					
Skin					
Abdominal					
Genitals					
Musculoskeletal					
Neck					
Shoulder					
Elbow					
Wrist					
Hand					
Back					
Knee Ankle					
Foot					
Dental					
	Circle A of B Below) Mu	st he signed hy	a Medical Doctor		
A. Cleared for physically strenuous p of daily running and various calisthB. Not Cleared due to:	hysical training (Boot Ca	amp/Military) p	rogram participation,		
Recommendations:					
Signature of MD:	Date:		Time:		
MD's Printed Signature:		Telephone Nu	mber:		
Address:					



Nar	ne:		Age:		Date of Birth:							
Histo	History must be completed by resident and parent/guardian prior to physical exam. Please provide completed form at physical.											
1.	Have you ever been hospitalized?						□ No					
2.	Have you ever had surgery?						□ No					
3.	Are you currently taking any medicine? If yes, please provide at least 30 day supply.						□ No					
4.	Have you ever passed out during or after exercise?						□ No					
5.	Have you ever had chest pains during or after exercise?						□ No					
6.	Do you tire more quickly than your friends during exercise?						□ No					
7.	Have you ever had high blood pressure?						□ No					
8.	Have you ever been told that you have a heart murmur?						□ No					
9.	Have	e you ever had a racing heartbeat or	felt like	e your heart skipped a be	at?	☐ Yes	□ No					
10.	Has	anyone in your family died of heart	problen	ns or a sudden death bef	ore age 50?	☐ Yes	□ No					
11.	Do y	ou have any skin problems (itches, i	ashes,	acne?)		☐ Yes	□ No					
12.	Are	you allergic to any food, drug, medic	cations	or stinging insect?		☐ Yes	□ No					
13.	Have	e you ever had a seizure?				☐ Yes	□ No					
14.	Hav	e you ever had a stinger, burner, or	pinched	nerve?		☐ Yes	□ No					
15.	Have	e you ever had heat or muscle cram	ps?			☐ Yes	□ No					
16.	. Have you ever been dizzy or passed out in the heat?						□ No					
17.	7. Do you have trouble breathing or do you cough during or after activity?						□ No					
18.	Do you have a history of asthma or breathing difficulties?						□ No					
19.	Do you use any special equipment (pads, braces, neck rolls, mouth/eye guard)?						□ No					
20.	Have you ever had any problems with your eyes or vision?						□ No					
21.	. Do you wear glasses or special eyewear? If yes, please provide.						□ No					
22.	Have you sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? If yes, any current issues?						□ No					
23.						☐ Yes	□ No					
24.							□ No					
25.		e you had any medical problems or i	☐ Yes	□ No								
26.		ou wear orthodontics (braces, retail		· · · · · · · · · · · · · · · · · · ·								
20.		ement?		.,. II yes, what is plan or	eure wille in	☐ Yes	□ No					
If yes	s to an	y questions, please explain:										
		·										
												
Resi	ident	Signature Date	!		Parent Signature		Date					