Post-Adjudication
Physical Evaluation Form

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

Name:_____ Age:_____ Date:_____

Height:_____ Weight:_____ BP:_____/_____ Pulse:_____

Vision: R 20/_____ L 20/_____ Corrected: Y _____ N _____ Pupils:_____

Immunization Reviewed & Current: Y _____ N _____ TB Test Administered (Date):_____

TB Test Read (Must be read within 48-72 hrs.) Date:_____ Time:_____ Results: Pos._____ Neg._____

	Normal	Abnormal Findings
Cardiopulmonary		
Heart		
Lungs		
Tanner Stage		
Skin		
Abdominal		
Genitals		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Dental		

Clearance: (Please Circle A of B Below) Must be signed by a Medical Doctor

A. **Cleared** for physically strenuous physical training (Boot Camp/Military) program participation, which will consist of daily running and various calisthenics including but not limited to: pushups, sit ups, jumping jacks, lunges.
B. **Not Cleared** due to:_____

Recommendations: _____

_____

Signature of MD:_____ Date:_____ Time:_____

MD's Printed Signature:_____ Telephone Number:_____

Address:_____

Post- Adjudication
Medical Screening Information

Clear Form

Name:		Age:		Date of Birth:	

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?	☐ Yes ☐ No
2.	Have you ever had surgery?	☐ Yes ☐ No
3.	Are you currently taking any medicine? If yes, please provide at least 30 day supply.	☐ Yes ☐ No
4.	Have you ever passed out during or after exercise?	☐ Yes ☐ No
5.	Have you ever had chest pains during or after exercise?	☐ Yes ☐ No
6.	Do you tire more quickly than your friends during exercise?	☐ Yes ☐ No
7.	Have you ever had high blood pressure?	☐ Yes ☐ No
8.	Have you ever been told that you have a heart murmur?	☐ Yes ☐ No
9.	Have you ever had a racing heartbeat or felt like your heart skipped a beat?	☐ Yes ☐ No
10.	Has anyone in your family died of heart problems or a sudden death before age 50?	☐ Yes ☐ No
11.	Do you have any skin problems (itches, rashes, acne?)	☐ Yes ☐ No
12.	Are you allergic to any food, drug, medications or stinging insect?	☐ Yes ☐ No
13.	Have you ever had a seizure?	☐ Yes ☐ No
14.	Have you ever had a stinger, burner, or pinched nerve?	☐ Yes ☐ No
15.	Have you ever had heat or muscle cramps?	☐ Yes ☐ No
16.	Have you ever been dizzy or passed out in the heat?	☐ Yes ☐ No
17.	Do you have trouble breathing or do you cough during or after activity?	☐ Yes ☐ No
18.	Do you have a history of asthma or breathing difficulties?	☐ Yes ☐ No
19.	Do you use any special equipment (pads, braces, neck rolls, mouth/eye guard)?	☐ Yes ☐ No
20.	Have you ever had any problems with your eyes or vision?	☐ Yes ☐ No
21.	Do you wear glasses or special eyewear? If yes, please provide.	☐ Yes ☐ 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?	☐ Yes ☐ No
23.	Do you wear any brace or assistive device? If yes, please provide.	☐ Yes ☐ No
24.	Have you had any other medical problems (infectious mononucleosis, diabetes, etc.)?	☐ Yes ☐ No
25.	Have you had any medical problems or injury since your last evaluation?	☐ Yes ☐ No
26.	Do you wear orthodontics (braces, retainer, etc.)? If yes, what is plan of care while in placement?	☐ Yes ☐ No

If yes to any questions, please explain:

_____ _____

Resident Signature Date Parent Signature Date