NJROTC Physical Participation Form

Name (Cadet): _____ Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: (_____)-_____

Grade: _____ Age: _____ Sex: _____ Date of Birth: _____ Place of Birth: _____

Father or Guardian's Name: _____ Employer: _____ Phone: (_____)-_____

Mother or Guardian's Name: _____ Employer: _____ Phone: (_____)-_____

Emergency Phone/Pager#: (_____)-_____ Cell: (_____)-_____ Email: _____

Family Physician: _____ Phone: (_____)-_____ School attended last semester: _____

Family Health Insurance CO. _____ Policy ID# _____

List all schools attended in the last twelve months: _____

Health Screening Questions	Y/N
1) Are you currently under a doctor's care for any reason?	
2) Have you ever been hospitalized?	
3) Have you ever had surgery?	
4) Are you currently taking any pills or medications?	
5) Do you have any allergies (Medicines, bee stings, etc.)?	
6) Have you ever been dizzy or fainted during or after excercise?	
7) Have you ever had chest pains during or after excercise?	
8) Have you ever had high blood preassure?	
9) Have you ever been told that you have had a heart murmur?	
10) Have you ever had a racing heart or skipped heartbeats?	
11) Have you ever had a head injury?	
12) Have you ever been knocked unconscious?	
13) Have you ever had a seizure?	
14) Have you ever been dizzy or passed out due to heat?	
15) Do you have any trouble breathing during or after excercise?	
16) Have you had any problems with your eyes or vision?	
17) Do you wear glasses, contacts, or protective eyewear?	
18) Do you use any special equipment (splints, neck rolls,mouth guards, etc.)?	
19) Has anyone in your family died of heart problems or died suddenly before the age of fifty?	
20) Do you have only one working organ of usually paired organs (only one eye, one kidney, etc.)?	
21) Have you ever sprained, broken, dislocated, or had repeated swelling or pain in any bones or joints?	
22) Is your Hand/ Wrist/ Elbow/ Forearm/ Hip/ Thigh/ Knee/ Ankle/ Shin/ Calf/ Foot currently bothering you?	
23) Have you ever had a stinger, burner, or pinched nerve?	
24) Have you ever had a medical problem or injury (asthma, mono, diabetes, etc.)?	
25) Have you had any medical problems since your last evaluation?	
26) Were there any special instructions or precautions given to you by a medical praticioner from your last evaluation?	
27) What was the date of your last tetanus shot?	

28) (Women only) Date of your last menstrual period: _____ Date of your first menstrual period: _____ Longest time between your periods: _____

I/we hereby state, to the best of my/our knowledge, that the answers to the questions for the medical history questionaire above are true. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for medical care of my/our child/ward. I/we varify that I/we have read and understand all material presented and all information I/we have provided is correct and I/we give permission for my/our child/ward to receive a physical examination to participate in NJROTC physical activities. In the event that all attempts to contact me/us or another parent/guardian of my child/ward at the above phone numbers meets with no success, full athorization is given for the administration of any treatment deemed necessary by a medical practitioner, and the transfer of my child/ward to any medical practitioner and to any licensed hospital or emergency clinic reasonably accessible. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of school authorities and aforesaid agent(s) to give reasonable care. Facts are provided above concerning my child/ward's medical history which a medical practitioner should know.

Signature of Cadet: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

BELOW FOR MEDICAL PRACTITIONER ONLY

	Blood Pressure	HEENT	Skin	Heart	Lungs	Abdomen	Flexibility/Strength
Normal							
Abnormal							

Cleared for NJROTC with the following restriction(s):_____

Cleared for participation in NJROTC Physical Activities: (YES) _____ (NO) _____

Doctor's Office Stamp: _____ Physical Signature: _____ Date: _____