

CADET BASIC COURSE (BC) – MEDICAL OPERATIONS PRE-PARTICIPATION PHYSICAL FORM

MEDICAL HISTORY FORM Name (Print:): _____

DATE OF EXAM: ____/____/____

Gender: Male Female

Age: ____ Date of birth: ____/____/____

Preferred Gender: Male Female

Are you now or have you ever been treated for any of the following:

Allergies:

	YES	NO	EXPLAIN				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>					
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>					
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>					
Skipped or irregular heart beats	<input type="checkbox"/>	<input type="checkbox"/>					
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>					
Ear/Sinus problems/ear tubes	<input type="checkbox"/>	<input type="checkbox"/>					
Heat Injury/stroke/rhabdomyolysis	<input type="checkbox"/>	<input type="checkbox"/>					
Psychiatric/psychological and emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>					
Learning Disorders (i.e. ADHD, ADD)	<input type="checkbox"/>	<input type="checkbox"/>					
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>					
Fainting spells/passed out/head injury	<input type="checkbox"/>	<input type="checkbox"/>					
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Seizures	<input type="checkbox"/>	<input type="checkbox"/>					
Sleep disorders (i.e. sleep apnea)	<input type="checkbox"/>	<input type="checkbox"/>					
GI Problems (i.e. abdominal, digestive)	<input type="checkbox"/>	<input type="checkbox"/>					
Surgery List when and what type:	<input type="checkbox"/>	<input type="checkbox"/>					
Serious injury/concussion When and what:	<input type="checkbox"/>	<input type="checkbox"/>					
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>					
Have you ever had an injury (e.g. sprained muscle or ligament tear, or tendonitis, that caused you to miss an athletic event) If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>					
Have you had any fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>					
Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, Physical Therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>					
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/Toes
FEMALES ONLY							
Have you ever had a menstrual period	<input type="checkbox"/>	<input type="checkbox"/>					
How old were you when you had your first menstrual period?	AGE:						
How many periods have you had in the last 12 months	#						

MEDICATIONS:

List all medications currently used. (If additional space is needed, please photo copy this part of the health form.)
Inhalers and EpiPen Information must be included, even if they are for occasional or emergency use only.

Medication:

Strength: _____ Frequency: _____

Reason for medication:

Date Started _____

Temporary Permanent

Medication:

Strength: _____ Frequency: _____

Reason for medication:

Date Started _____

Temporary Permanent

Medication:

Strength: _____ Frequency: _____

Reason for medication:

Date Started _____

Temporary Permanent

Medication:

Strength: _____ Frequency: _____

Reason for medication:

Date Started _____

Temporary Permanent

Medication:

Strength: _____ Frequency: _____

Reason for medication:

Date Started _____

Temporary Permanent

Be sure to bring medications in the original containers and make sure they are NOT expired, including inhalers and EpiPens (approved). You SHOULD NOT STOP taking any maintenance medications. If applicable, ensure you bring two pairs of glasses and prescription.

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MEDICAL EXAM FORM

Name (Print): _____ Date of birth: _____
 Height: _____ Weight: _____ No Pulse: _____ BP: _____ / _____ (_____ / _____)
 Vision R 20/ _____ L 20/ _____ Corrected: YES NO Pupils : EQUAL UNEQUAL

	NORMAL	ABNORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL				
Eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Ears	<input type="checkbox"/>	<input type="checkbox"/>		
Nose	<input type="checkbox"/>	<input type="checkbox"/>		
Throat	<input type="checkbox"/>	<input type="checkbox"/>		
Pulses	<input type="checkbox"/>	<input type="checkbox"/>		
Lungs	<input type="checkbox"/>	<input type="checkbox"/>		
Heart	<input type="checkbox"/>	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>		
Skin	<input type="checkbox"/>	<input type="checkbox"/>		
Genitalia (males only)	<input type="checkbox"/>	<input type="checkbox"/>		
Inguinal Hernia	<input type="checkbox"/>	<input type="checkbox"/>		
Emotional Adjustment	<input type="checkbox"/>	<input type="checkbox"/>		
MUSCULOSKELETAL				
Neck	<input type="checkbox"/>	<input type="checkbox"/>		
Back	<input type="checkbox"/>	<input type="checkbox"/>		
Shoulder/arm	<input type="checkbox"/>	<input type="checkbox"/>		
Elbow/forearm	<input type="checkbox"/>	<input type="checkbox"/>		
Wrist/hand	<input type="checkbox"/>	<input type="checkbox"/>		
Hip/thigh	<input type="checkbox"/>	<input type="checkbox"/>		
Knee	<input type="checkbox"/>	<input type="checkbox"/>		
Leg/ankle	<input type="checkbox"/>	<input type="checkbox"/>		
Foot	<input type="checkbox"/>	<input type="checkbox"/>		
OTHER				
Glasses (contacts)	<input type="checkbox"/>	<input type="checkbox"/>		
Braces	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Allergies (to what agent, type of reaction, treatment)

Activities at BC each Cadet must be able to fully participate in are:

- 1) Obstacle Courses involving running, jumping, climbing/scaling and lifting.
- 2) A two mile run for time.
- 3) Maximum pushups for time.
- 4) Maximum sit-ups for time.
- 5) Small unit patrols involving walking many miles wearing metal plated vest, knee/elbow pads, military helmet, rifle and military uniform.
- 6) 10 mile mark wearing 45 lbs of weight in a large backpack.
- 7) Land navigation involving walking 4-5 miles at a rigorous pace over rugged terrain.
- 8) Daily Physical Fitness Training (PRT) using calisthenics, weights and repetitive movements.

I certify that I have, today, reviewed the health history, examined this person and approved this individual for participation in the above listed activities:

BC Cleared without restriction
 BC Cleared with recommendations for further evaluation or treatment for:

 Not cleared for: Physical Fitness Activities, Specific Activities:

 Reason:

HCP Printed Name _____
 MD / DO / NP / PA-C
 Signature: _____
 Address: _____
 City, State, Zip _____
 Office Phone: _____
 Date: _____