



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

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

If yes to any questions, please explain:

Resident Signature

Date

Parent Signature

Date