HEALTH RISK SCREENING QUESTIONNAIRE

CADET NAME: _____

SCHOOL NAME: _____

Date of cadet's most recent pre-participation sports physical: _____

PART A – TO BE COMPLETED BY THE CADET AND PARENT/GUARDIAN
(Circle the appropriate response to **EACH** question)

1. Have you had a medical illness, injury or surgery since your last check up or sports physical?	**Yes**	**No**
2. Do you have difficulty doing strenuous (great effort) exercise?	**Yes**	**No**
3. Do you have a medical notice from your physician to **NOT** to participate in long distance runs, such as a 1-mile-run?	**Yes**	**No**
4. Do you have a medical notice from your physician that you are **NOT** to do curl-ups or push-ups?	**Yes**	**No**
5. Do you exercise less than three times per week for at least thirty minutes?	**Yes**	**No**
6. Have you had any broken bones, a serious accident, or <u>any type of</u> surgery in the last six months?	**Yes**	**No**
7. Do you use tobacco of any kind?	**Yes**	**No**
8. Have you experienced chest, neck, jaw or arm discomfort while doing physical activity?	**Yes**	**No**
9. Do you have difficulty breathing or have sudden breathing problems at night?	**Yes**	**No**
10. Has Asthma ever been documented in any of your medical records growing up?	**Yes**	**No**
11. Do you currently have Asthma?	**Yes**	**No**
12. Are you using an inhaler to aid in breathing?	**Yes**	**No**
13. Do you experience any shortness of breath with relatively low levels of exercise or exertion?	**Yes**	**No**
14. Have you felt any chest pain at rest?	**Yes**	**No**
15. Do your medical records contain any known cardiac (heart) disease?	**Yes**	**No**
16. According to the Navy's height/weight table published on line at: https://www.navycs.com/navyheightweightchart.html are you overweight?	**Yes**	**No**
17. Has your physicians limited any activity due to dizzy/fainting spells, frequent headaches, or frequent back pains?	**Yes**	**No**
18. Have you ever experienced dehydration after strenuous physical exercise that has resulted in your physician now recommending or limiting certain physical activities?	**Yes**	**No**
19. Are you currently under treatment by a physician or other medical practitioner?	**Yes**	**No**
20. Has your mother or sister died without any explanation or suffered a heart attack before the age of 55?	**Yes**	**No**
21. Has your father or brother died without any explanation or suffered a heart attack before the age of 45?	**Yes**	**No**

22. Do you have high blood pressure or are you on blood pressure medication? **Yes** **No**
23. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication? **Yes** **No**
24. Do you have diabetes? **Yes** **No**
25. Have you experienced episodes of rapid beating or fluttering of the heart? **Yes** **No**
26. Do you suffer from lower leg swelling of both legs? **Yes** **No**
27. Is there any history of metabolic disease (thyroid, renal, liver) listed in any of your medical records? **Yes** **No**
28. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises? **Yes** **No**
29. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFA? **Yes** **No**
30. Have you ever been diagnosed with Sickle Cell Trait? **Yes** **No**
31. Do you have a current prescription for epinephrine (or "epi" pen) for situational use? **Yes** **No**
32. Are you currently taking any prescription or non-prescription (over the counter) medications or pills? **Yes** **No**
33. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters, pressure sores, or bites) of any kind? **Yes** **No**
    If **Yes**, Please specify: _____
34. Have you ever become ill from exercising in the heat? **Yes** **No**

_____ _____

Cadet Signature/Date Parent/Guardian Signature/Date

PART B – TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER

(If any of the answers to the questions above were **YES,** the following section must be completed and signed by a licensed medical practitioner)

1. List significant clinical history and/or current medication and treatment regimen of the above cadet: (Use below as necessary)

2. Recommended/released for participation in strenuous physical activities including the mile run.

Yes **No**

_____ _____

Signature of Medical Practitioner Date

NAVAL JUNIOR RESERVE OFFICERS TRAINING CORPS (NJROTC) STANDARD RELEASE FORM

Date: _____

I, _____, being the legal parent/guardian of _____, a member of the Naval Junior Reserve Officers Training Corps, in consideration of the continuance of his/her membership in the Naval Junior Reserve Officers Training Corps and/or his/her acceptance for Naval Junior Reserve Officers Training Corps training, do hereby release from any and all claims, demands, actions, or causes of action, due to death, injury, or illness, the government of the United States and all its officers, representatives, and agents acting officially and also the local, regional, and national Navy Officials of the United States.

I hereby authorize personnel of the Department of Defense, Armed Forces, Public Health Service, or civilian physicians to render such medical and dental care as may be necessary and medically indicated in the case of my son/daughter/ward during his/her period of training, as is deemed necessary by a qualified practitioner.

I understand that care at a military medical facility for non-military dependents will normally be rendered on a temporary (emergency) basis only: if further care is indicated, the patient will be transferred to non-military care as soon as possible. Emergency care provided to cadets who are not military dependents at a military facility may be subjected to reimbursement, and I may be billed for the care provided. For Navy Medical Department facilities, such care is authorized by NAVMEDCOMINST 6320.3B.

My son/daughter/ward has been determined to have the following allergies:

He/she requires medication for the treatment of:

Below are listed other medical conditions which my son/daughter/ward is known to have, which would preclude or limit in any way his/her participation in physical exercise and athletic programs.

His/her physician is:

Name:

Address:

Telephone (include area code):

Initials _____

Medical Insurance Company *
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

Dental Insurance Company*
Name:
Street:
City, State, Zip Code:
Policy/ID Number:
Telephone Confirmation Number: ( )

***This insurance is not required. However, the information provided may be required to obtain non-emergency care.**

PRIVACY ACT NOTIFICATION

Under the authority of 5 U.S.C. Sec. 301, the information regarding your child's/ward's health, medical condition and treatment is requested in order to verify any need to administer medication and to enable medical/dental personnel to diagnose and treat any emergency condition which may arise during training. Pursuant to the Privacy Act, 5 U.S.C. Sec. 552, the requested information will not be divulged without your written authorization to anyone other than NJROTC area personnel involved with administration of NJROTC activities and medical/dental personnel requiring the information in order to effectively treat any medical/dental problem which may arise. Disclosure is voluntary: however, failure to provide the requested information will preclude your child's/ward's participation in the training.

Signature of Parent or Guardian:		
Address:		
City:	State:	Zip:
Telephone (include area code):		