



Sports Physical Exam Form

Dear Physician,

Your patient has applied to attend the Arkansas National Guard Youth ChalleNGe Program at Camp Robinson. This program is a 22-week quasi-military behavior modification program. Students participate in physical training twice daily throughout the program. This may include running, stretching, pushups, sit ups, leg lifts, jumping jacks, or other military-style exercises. The first two weeks will involve rigorous exercise, up to and including a 10 mile road march. All applicants must obtain a sport's physical and release from a physician in order to attend the program. **This form MUST be completed so that we may make an informed decision on the potential candidate's participation.**

Applicants Name	Date of Birth	Exam Date
Height _____ Weight _____	Corrected Vision	Uncorrected Vision
	R _____ / _____	R _____ / _____
Pulse _____ BP _____	L _____ / _____	L _____ / _____

	Normal	Abnormal findings	Initials
1. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Ears, Nose, Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Mouth and Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Chest and Lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Genitalia-Hernia (male)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Musculoskeletal: ROM, strength, etc	<input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Neuromuscular	<input type="checkbox"/> Yes <input type="checkbox"/> No		

I have reviewed the data above, my patient's medical history, and make the following recommendations for his/her participation in the Arkansas National Guard Youth ChalleNGe Program:

CLEARED WITHOUT RESTRICTIONS CLEARED WITH THE FOLLOWING RESTRICTIONS

PARTICIPATION RESTRICTIONS: _____

NOT CLEARED FOR PARTICIPATION

Physicians Name and degree (please print)

Address /City / State / Zip / Phone #

Physicians Signature: _____