CIVILIAN STUDENT TRAINING PROGRAM PHYSICAL EVALUATION

All Personally Identifiable Information Below is Protected by the Privacy Act and HIPAA.

Patient's Name: ______________________________ **Date of Birth:** __________

Height: ____ **Weight:** _____ **Pulse:** _____ **BP:** _______

Medical	Normal	Abnormal Findings	Provider Initials
Appearance			
Ears/Nose/Throat			
Vision	Right: 20/__ Left: 20/__	Pupils Equal: Y / N	
Lymph Nodes			
Heart			
Pulse			
Lungs			
Abdomen			
Genitalia			
Skin			
Neck			
Back			
Shoulders/Arms			
Elbows/Forearms			
Wrists/Hands			
Hips/Thighs			
Knees			
Legs/Ankles			
Feet			

Does the student have any physical conditions that would prevent him from activities of daily living or physical fitness? Y / N
If Yes, Please explain:

Clearance

___ Cleared to fully participate in all aspects of the program

___ Not Cleared to fully participate in all aspects of the program Reason:

Current Prescription Medications

Medication Name	**Reason for Rx**	**Dosage**

Is the student current on all required immunizations? Y / N

Medical Facility:________________________ Address: ______________________________ Phone: __________

Printed Provider Name:

Provider Signature: