



## Student Health Data

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Last First Middle

School Name: \_\_\_\_\_ School Number: \_\_\_\_\_

Commander Name: \_\_\_\_\_ Commander Email: \_\_\_\_\_

Do you have any physical or psychological limitations/injuries that might in any way restrict your full participation in physical activities during training?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
 Student's Signature Date

**This section to be completed by medical professional (medical doctor (MD), osteopath (DO), physician's assistant (PA), or certified nurse practitioner (CNP), licensed by the Ohio State Medical Board or the Ohio State Board of Nursing, or a neighboring state's equivalent, or a medical professional with the US Department of Veterans' Affairs.):** This physical examination should ascertain any conditions which may preclude the student's ability to participate in, or which may be aggravated by, strenuous physical exercise. As a part of peace officer basic training, the student will engage in calisthenics, running, jumping, wrestling, unarmed self-defense, firearms, driving and other physically demanding exercises.

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds Resting Pulse Rate: \_\_\_\_\_ beats per minute Blood Pressure: \_\_\_\_\_/ \_\_\_\_\_

Does the patient have a medical history of, or presently demonstrate symptoms of, any of the following?

- | Yes   | No    |                                     | Yes   | No    |   |
|-------|-------|-------------------------------------|-------|-------|---|
| _____ | _____ | 1. Uncorrected visual deficiency    | _____ | _____ | 9. Dizziness/Fainting                   |
| _____ | _____ | 2. Major impairment of the senses   | _____ | _____ | 10. Back/Neck injury or recurrent pain  |
| _____ | _____ | 3. Asthma or Breathing difficulties | _____ | _____ | 11. Pregnancy                           |
| _____ | _____ | 4. Heart attack; Angina Pectoris    | _____ | _____ | 12. Communicable diseases               |
| _____ | _____ | 5. Stroke                           | _____ | _____ | 13. Amputation/Prosthetic devices       |
| _____ | _____ | 6. Hemorrhage                       | _____ | _____ | 14. Bone/joint injury or recurrent pain |
| _____ | _____ | 7. Hypertension                     | _____ | _____ | 15. Taking medication                   |
| _____ | _____ | 8. Allergies _____                  | _____ | _____ | 16. Under physician's continuing care   |

Please note any other condition(s) not listed above which may affect the student's participation. Also please explain each "Yes" response above, indicating the item number:

As a result of my physical examination, I have determined that the student can, without limitation, safely function in all phases of strenuous physical training including, but not limited to, calisthenics, running, jumping, wrestling, unarmed self-defense, firearms, driving and a physical fitness assessment consisting of sit-ups, push-ups, and a timed 1.5 mile run.

\_\_\_\_\_  
 Signature of Medical Professional

\_\_\_\_\_  
 Printed/Typed Name with Title (MD, DO, PA or CNP)

\_\_\_\_\_  
 License Number Issuing State

\_\_\_\_\_  
 Phone Number

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Date of Examination

\_\_\_\_\_  
 City, State, Zip

**\*Please give completed form back to the student to return to the commander or send to the above noted commander's email address.**