

Health Risk Screen

NJROTC HEALTH RISK SCREENING QUESTIONNAIRE

Cadet Name: _____ (Printed Name)

NJROTC Unit: _____ High School

Date of your most recent pre-participation sports physical examination _____

Part A – TO BE COMPLETED BY THE CADET AND PARENT/GUARDIAN

Directions: Please answer **Yes** or **No** to the following questions: (Do not leave any questions blank)

- | | |
|--|--|
| 1. Do you have difficulty doing strenuous (great effort) exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you been told NOT to participate in long distance runs, such as a 1.5-mile-run? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you been told NOT to do curl-ups or push-ups by a physician or other medical professional? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you exercise less than three times per week for at least thirty minutes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you had any broken bones or a serious accident in the last three months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Do you use tobacco of any kind? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you experienced chest, neck, jaw or arm discomfort while doing physical activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you have asthma or are you using an inhaler to aid in breathing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you experience any shortness of breath with relatively low levels of exercise or exertion? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. In the last month have you felt any chest pain at rest? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Do you have any known cardiac (heart) disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Do you think you are overweight? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Do you have dizzy/fainting spells, frequent headaches, or frequent back pains? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Have you ever experienced dehydration after strenuous physical exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Are you currently under treatment by a physician or other medical practitioner? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Has your mother or sister died without any explanation or suffered a heart attack before the age of 55? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Has your father or brother died without any explanation or suffered a heart attack before the age of 45? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Do you have high blood pressure or are you on blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Do you have sugar diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Have you experienced episodes of rapid beating or fluttering of the heart? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Do you suffer from lower leg swelling of both legs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Do you have difficulty breathing or have sudden breathing problems at night? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Do you have any personal history of metabolic disease (thyroid, renal, liver)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFT? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Have you ever been diagnosed with Sickle Cell Trait? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Cadet Signature

Date

Parent/Guardian Signature

Date

Part B - If any of the answers to the questions above were **YES**, request that the following section be completed and signed by a licensed medical doctor or registered school nurse:

Significant clinical history and/or current medication and treatment regimen of the above cadet: (Use reverse side if necessary)

Recommended/released for participation in strenuous physical activities including the 1.5-mile-run? ☐ Yes ☐ No

Signature of Medical Practitioner

Date

CNET Form 1533/106 (09-02)

Standard Release Form

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

Date _____

I, _____, being the legal

parent/guardian of _____, a member of the **Upton Lee High School 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):

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):_____

Parent/ Guardian Email address_____

(The reason we are asking for your email, we send a monthly newsletter to the parents about NJROTC information or unit updates.)

MEDIA RELEASE FORM

Date: _____

I, _____, being the
legal parent/guardian of _____, a
member of the Naval Junior Reserve Officers Training Corps, hereby give my consent to
have his/her photograph released to the local media including local newspapers and/or
published on the official NJROTC website if/when appropriate. Photographs are typically
taken during local events attended by the NJROTC including sporting events,

parades, and ceremonies.

_____ Yes

_____ No

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

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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Physical Evaluation Form

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/____ L 20/____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 	<input type="checkbox"/>	

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

☐ Medically eligible for certain sports

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____
