



Student Health Data

Name:		F:4			Age:	Sex: Male	Female	
School Name	Last	First		Middle	School Nu	mher:		
			School Number:					
Commander N	Vame:		Comma	ander Email:				
Do you have training?	any physical or	psychological limitations/inju	ries that migh	t in any way	restrict your f	ull participation in	physical activities during	
Yes _	No If yes	, please describe:						
Student's Signature				Date				
practitioner (medical profe student's ability calisthenics, run Height:	CNP), licensed essional with the to participate in, outling, jumping, wro feet inc.	by medical professional (med by the Ohio State Medical B t US Department of Veterans or which may be aggravated by, structures, unarmed self-defense, fireathes thes Weight: pound	oard or the O Affairs.): The enuous physical rms, driving and serving and serv	hio State Bo his physical ex exercise. As a d other physical Pulse Rate:	ard of Nursing amination should a part of peace off ally demanding ex beats po	s, or a neighboring ascertain any conditi- icer basic training, the ercises. er minute Blood	state's equivalent, or a ons which may preclude the e student will engage in	
Does the patie	nt have a medica	l history of, or presently demo	nstrate sympto	oms of, any o	f the following	?		
Yes No			Yes	No				
	1. Uncorrected	d visual deficiency		9. D	izziness/Faintir	ıg		
	Major impa	irment of the senses		10. B	ack/Neck injury	or recurrent pain		
	3. Asthma or	Breathing difficulties		11. P	regnancy			
	4. Heart attack	x; Angina Pectoris		12. C	ommunicable d	iseases		
	5. Stroke			13. A	mputation/Pros	thetic devices		
	6. Hemorrhag	e		14. B	one/joint injury	or recurrent pain		
	7. Hypertension	on		15. T	aking medication	on		
	8. Allergies _			16. U	nder physician	s continuing care		
Please note any number:	other condition(s)	not listed above which may affect	et the student's	participation.	Also please expla	nin each "Yes" respon	nse above, indicating the iten	
including, but		nation, I have determined that t isthenics, running, jumping, wre 5 mile run.						
Signature of Medical Professional				Printed/Typed Name with Title (MD, DO, PA or CNP)				
License Number	tense 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.

SF114bas Page 1 of 1 Revised 6/16/2020