

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-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 |
| 28. Do you have a current prescription for epinephrine (or "epi" pen) for situational use? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

If you answered yes to any question please continue to the second page.

Cadet Signature _____

Date _____

Parent/Guardian Signature _____

Date _____

Cadet Name:

Part B – TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER

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 below as necessary)

Recommended/released for participation in strenuous physical activities including the 1.0-mile-run?

Yes No

Signature of Medical Practitioner

Date