

Name: _____ DOB: _____

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University of North Georgia Cadet Physical Evaluation

To Be Completed by a Healthcare Provider

A healthcare provider is a licensed Physician, Nurse Practitioner, or Physician Assistant.

(For your health, safety, and continuity of care, it is strongly preferred that your medical evaluation and any required documentation to be completed by a Healthcare Provider who is familiar with your medical history and ongoing care.)

For staff to be adequately informed and plan accordingly for cadet participation, all medical conditions that may impact involvement in Corps activities — including prolonged standing and marching — must be identified below.

Cadets are expected to meet the following standards within one academic year:

- Corps Physical Fitness Test (PFT)
 - Pushups
 - Planks
 - Deadlifting minimum of 185lbs
 - 2-mile run
- Meet established weight or body fat standards

Additionally, cadets are expected to participate in:

- Daily physical training
 - 2 to 5-mile group runs
 - Obstacle or stamina courses
 - Functional fitness workouts
 - Foot marches up to 12 miles with a 35lb rucksack
 - Field training exercises
-

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CORPS OF CADETS PREPARTICIPATION PHYSICAL EVALUATION MEDICAL HISTORY

List any limiting medical, psychological, or emotional conditions requiring ongoing treatment and/or medication.

Existing Medical Concerns or Conditions

(Please print or type)

Condition	Yes No		Diagnosed Date	Comments	Healthcare Provider Initials
	Yes	No			
Asthma / Last Attack	<input type="checkbox"/>	<input type="checkbox"/>			
Inhaler Use	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Disease / Family History	<input type="checkbox"/>	<input type="checkbox"/>			
Other Cardiac Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
Head Trauma / Concussion	<input type="checkbox"/>	<input type="checkbox"/>			
Seizure / Last Seizure	<input type="checkbox"/>	<input type="checkbox"/>			
Lung / Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Ear / Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes (Type 1 / Type 2)	<input type="checkbox"/>	<input type="checkbox"/>			
Psychiatric / Psychological	<input type="checkbox"/>	<input type="checkbox"/>			
ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Musculoskeletal Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery (Procedure / Date)	<input type="checkbox"/>	<input type="checkbox"/>			

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Fitness Level (Past Year)

Mild Moderate Elite

(Mild: 0–1 workouts/week; Moderate: 2–4 workouts/week; Elite: 5+ workouts/week, >30 min each)

Allergies

Requires EpiPen? Yes No

Medications

Yes (list below) No

Medication Name	Dosage	Frequency	Related Condition

Physical Examination

Height: _____		Weight: _____	
BP: / (/)	Pulse: _____	Vision: R 20/ L 20/	Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N

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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) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional Double-leg squat test, single-leg squat test, and box drop or step drop test		

Additional Comments

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Clearance (Healthcare Provider Section)

I certify I have reviewed the lifestyle and activities listed on page 1, and this individual is cleared to participate without limitations.

Cleared

***Clearance will not be granted by the Healthcare Provider without performing a physical exam.**

Cleared after completing evaluation/rehabilitation for:

Not Cleared for:

Recommendations:

Healthcare Provider Certification

This form must be completed and signed by a **Healthcare Provider** licensed by a State Board. Forms signed by any other provider will not be accepted.

Provider Name (Print/Type): _____

Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____