

Last Name, First Name: _____ DOB: _____ Age: _____

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 recommended that your medical evaluation and any required documentation is completed by a healthcare provider who is familiar with your medical history and ongoing care. Physical examinations completed by immediate family members cannot be accepted.

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 year within one academic year:

- Corps Physical Fitness Test (PFT)
 - Pushups
 - Planks
 - Deadlifting a minimum of 185 lbs
 - 2-miles run
- Meet established weight and 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 35 lb rucksack
- Field training exercises

Last Name, First Name: _____ DOB: _____ Age: _____

CORPS OF CADETS PREPARTICIPATION MEDICAL HISTORY FORM

Provide current or past health conditions. Healthcare provider completing the physical examination should review and verify.

Current or Past History	Yes	No	Specific Diagnosis (Required if Yes)	Year Diagnosed or First Occurrence	Current Treatment/Medication	Restrictions, Accommodations, or Comments	Initials MD/DO/ NP/PA
Asthma or Reactive Airway Disease							
Exercise-Induced Asthma							
Severe Allergies (food, medication, insect sting, environmental)							
History of Anaphylaxis							
Heart Disease or Cardiac Condition							
Heart Murmur or Abnormal Heart Rhythm							
High Blood Pressure							
Chest Pain During Exercise							
Fainting or Syncope							
Seizure Disorder							
Migraine or Chronic Headache Disorder							
Concussion or Significant Head Injury							
Neurologic Disorder							
Sleep Disorder (including Sleep Apnea)							
Hearing Loss							
Vision Disorder (other than corrective lenses)							
Diabetes							
Thyroid Disorder							
Kidney Disease							
Gastrointestinal Disorder							
Bleeding or Clotting Disorder							

Last Name, First Name: _____ DOB: _____ Age: _____

Medical History continued.

Current or Past History	Yes	No	Specific Diagnosis (Required if Yes)	Year Diagnosed or First Occurrence	Current Treatment/Medication	Restrictions, Accommodations, or Comments	Initials MD/DO/ NP/PA
Sickle Cell Trait							
Sickle Cell Disease							
Musculoskeletal Disorder or Injury (including previous fractures)							
Recurrent Joint Instability or Dislocations							
Back or Spine Disorder							
Skin Disorder Requiring Ongoing Treatment							
Psychiatric or Psychological Disorder							
Attention Deficit Hyperactivity Disorder (ADHD)							
Autism Spectrum Disorder							
History of Heat Exhaustion or Heat Stroke							
Surgeries							
Other Significant Medical Condition							

List any current medical, psychological, or emotional conditions and ongoing treatment and/or medication not addressed or provide additional information for the conditions above.

Last Name, First Name: _____ DOB: _____ Age: _____

Fitness Level

(To be completed by patient and reviewed by the healthcare provider completing the physical examination.)

What would you consider your current fitness level?

- ☐ **Low** (0-1 workouts per week)
- ☐ **Active** (2-3 workouts per week, most 30+ minutes)
- ☐ **Fit** (5-6 workouts/week, >30 minutes each, consisting of cardiovascular and strength training)
- ☐ **Advanced/Competitive** (6+ workouts/week with structured training, endurance events, fitness competitions or performance-focused goals)

Medications

Medication	Dose	Frequency	Related Condition

Allergies

_____ No known allergies

List medication, food or environmental allergies here. Include reaction.

EpiPen Required? _____ Yes _____ No

Last Name, First Name: _____ DOB: _____ Age: _____

Physical Examination

Vital Signs and Vision				
Height:	Weight:	Vision R 20/	L 20/	Corrected? Y N
BP: /	Pulse:	Resp:	Temp:	
Medical	Normal	Abnormal		
General appearance (Include evidence of Marfan stigmata - kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)				
Eyes, Ears, Nose, and Throat - include pupils and hearing				
Lymph nodes				
Heart – including murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)				
Lungs				
Abdomen				
Skin – including herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis				
Neurological				
Mental Health				
Musculoskeletal Exam include range of motion and strength	Normal	Abnormal		
Neck				
Back – include screening for scoliosis				
Shoulders and Upper Arms				
Elbows, Forearms				
Wrists, Hands, and Fingers				
Hips and Thighs				
Knees				
Lower Legs and Ankles				
Feet and Toes – include assessment of arches				
Functional – Double-leg squat, single-leg squat, and box drop or step drop tests				

Last Name, First Name: _____ DOB: _____ Age: _____

Clearance and Healthcare Provider Certification

Clearance cannot be granted by the healthcare provider without performing a physical examination.

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

☐ **Cleared without restrictions.**

☐ **Requires further evaluations or rehabilitation for:**

☐ **Not cleared due to:**

Recommendations:

Healthcare Provider Certification

This form must be completed and signed by a Healthcare Provider licensed by a State Board.

Forms signed by a provider other than an MD, DO, NP or PA will not be accepted.

Provider name and credentials (Print): _____

Signature: _____ Date of Examination: _____

Complete Address & Phone Number of Practice (or stamp): _____

