

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