

Are you allergic to any medications, foods or other agents such a bee stings, wool etc.? YES NO
 If yes, please list the agent and the reaction to it.

| Allergen: | Reaction: | Treatment? |
|-----------|-----------|------------|
| | | |
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| | | |

Have you ever been admitted to a hospital for substance abuse, mental health or behavior?
 If yes, please list the date, hospital and reason for treatment. You must also provide a YES NO
 discharge summary for each case of inpatient care.

| MO/YR | Hospital | Treatment? |
|-------|----------|------------|
| | | |
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| | | | | | | |
|--|---|-------------------------------------|---|---------------------------------|--|-----------------------------------|
| Have you ever been treated for: | | | | | | |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> BiPolar Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Conduct Disorder | <input type="checkbox"/> ODD | <input type="checkbox"/> Obsessive Compulsive Disorder | |
| Suicide Attempt(s)? | | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If yes, date: _____ | | |
| Rehab for Drug or Alcohol Abuse: | | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If yes, date: _____ | | |
| Have you ever used? | | | | | | |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Crack | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Heroin | <input type="checkbox"/> Xanax | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Spice/K2 |
| Alcohol of Choice | | <input type="checkbox"/> Beer | <input type="checkbox"/> Wine | <input type="checkbox"/> Liquor | | |
| Do you smoke or use tobacco products? | | | <input type="checkbox"/> YES | <input type="checkbox"/> NO | How Often? _____ | |

Applicant Name: _____

Do you have or have you ever been treated for any of the following:

| | NO | YES | | | NO | YES | |
|-----|----|-----|-------------------------------------|-----|----|-----|---------------------------------------|
| 1. | | | Headaches, Migraines or Clusters | 23. | | | Diabetes/Hypoglycemia |
| 2. | | | Severe Head Injuries | 24. | | | Thyroid Problems |
| 3. | | | Loss of Consciousness | 25. | | | Kidney/Urinary Problems |
| 4. | | | Seizures/Convulsions | 26. | | | Intestinal Problems |
| 5. | | | Heart Disease/Murmurs/Irregular HB | 27. | | | Bedwetting (since age 14) |
| 6. | | | Chest Pain | 28. | | | Severe Acne |
| 7. | | | High Blood Pressure | 29. | | | Frequent Stomachaches/Ulcers/Reflux |
| 8. | | | Circulation Problems | 30. | | | Staph Infection |
| 9. | | | Anemia/Sickle Cell/Blood Disorder | 31. | | | Athletes Feet/Skin Fungus |
| 10. | | | Unexplained Sweating | 32. | | | Cold/Heat Intolerance |
| 11. | | | Dizziness/Fainting Spells | 33. | | | Allergies |
| 12. | | | Neck and/or Back Problems | 34. | | | Tuberculosis/Positive TB Test |
| 13. | | | Scoliosis | 35. | | | Depression/ADHD/Bipolar |
| 14. | | | Muscle Cramps | 36. | | | Mental Illness/Psychological Disorder |
| 15. | | | Pins/Screws/Rods | 37. | | | Hearing Impairment |
| 16. | | | Flat Feet | 38. | | | Communicable Diseases |
| 17. | | | Broken Bones | 39. | | | Adverse Reaction to Drugs |
| 18. | | | Arm/Shoulder Problems | | | | FEMALES ONLY: |
| 19. | | | Hip/Knee/Ankle/Foot Problems | 40. | | | Heavy or Difficult Menstrual Cycle |
| 20. | | | Wheezing/Asthma/Shortness of breath | 41. | | | Untreated Abnormal Vaginal Discharge |
| 21. | | | Anorexia/Bulimia | 42. | | | Are you Pregnant? |
| 22. | | | Hepatitis/Liver Problems | | | | |

All yes responses must be explained by number. You may use the back of this page if necessary.

Applicant Name: _____

PHYSICIAN'S EXAMINATION

Age: _____ Height: _____ Weight _____ Pulse: _____ BP: _____

Glasses: YES NO Color Vision: YES NO

| Normal | Physical Examination | Abnormal | Comments |
|--------|--------------------------------|----------|----------|
| | Head, Face, Neck, Scalp | | |
| | Nose | | |
| | Sinuses | | |
| | Mouth and Throat | | |
| | Ears – General | | |
| | Eardrums | | |
| | Eyes – General | | |
| | Pupils | | |
| | Ocular Motility | | |
| | Lungs and Chest | | |
| | Heart | | |
| | Vascular System | | |
| | Abdomen/Viscera | | |
| | GU System | | |
| | Upper Extremities | | |
| | Feet | | |
| | Lower Extremities | | |
| | Spine | | |
| | Identifying Body Marks | | |
| | Skin/Lymphatic System | | |
| | Neurological System | | |
| | Psychiatric | | |

As the attending physician, I have reviewed the medical history of the above named applicant. I have also read the cover letter addressed to me explaining the program. I have conducted a complete sports physical and **have found the applicant to be physically capable** to participate completely in all strenuous activities with no limitations.

Additional comments may be written on the back of this form.

(PRINT) Physician's Name

Physician's Signature

Date of Exam

Address

Phone Number

City State Zip Code

Applicant Name: _____