

**AFROTC PRE-PARTICIPATORY SPORTS PHYSICAL**

Name of Candidate: \_\_\_\_\_ AFROTC Detachment \_\_\_\_\_

I, \_\_\_\_\_, have examined this candidate and reviewed his/her medical history. I have found no medical condition or physical impairment, which would preclude this candidate from participating in a physical training program designed to meet and or exceed the AFROTC standards listed below:

	<b>Push-Ups</b>	<b>Crunches</b>	<b>1.5 Mile Run</b>
<b>Male</b>	<b>33</b>	<b>40</b>	<b>12:30</b>
<b>Female</b>	<b>18</b>	<b>35</b>	<b>14:30</b>

\_\_\_\_\_  
Signature of Physician or Medical Authority\_\_\_\_\_  
Date of Examination

The Privacy Act of 1974; F036 AETCI AUTHORITY 10 U.S.C 33; 10 U.S.C 103; AFI 36-2001; AFI 45-3 and E.O. 9397 (SSN) grants the authority of this form to be used for screening a candidate for participation as an AFROTC cadet in the AFROTC Physical Training (PT) Program. This form is for internal use only. Disclosure is voluntary; failure to disclose will result in a requirement for a new physical, inability to participate in PT activities, and or disenrollment from the AFROTC program.

AFROTC PHYSICAL HEALTH SCREENING QUESTIONNAIRE

**To The Cadet:** It is mandatory to complete this screening prior to participating in the Cadet Physical Training (PT) Program. Return this completed questionnaire to your personnel NCO, and advise the NCO if you responded, "yes" to any of the questions below.

- 1. Has there been any significant change to your health in the past 6 months? YES - NO
- 2. Are you currently on a medical profile exempting you from PT activities? YES - NO
- 3. Has a physician ever indicated you have heart disease or heart trouble? YES - NO
  - a. Do you suffer from pains in your chest, especially with physical activity? YES - NO
  - b. Do you feel faint or have dizzy spells during or after physical activity? YES - NO
- 4. Have you experienced a significant weight change in the past 6 months? YES - NO
  - a. If "Yes", indicate the estimated amount gained or lost: \_\_\_ lbs.
- 5. Have you ever been diagnosed or displayed symptoms of heat stress? YES - NO
- 6. Females only: Are you pregnant or do you think you may be pregnant? YES - NO
- 7. Do you take any dietary, herbal or nutritional supplements, which contain any of the following substances: Ephedra/Ephedrine, Guarana, Phenylephrine, Pseudoephedrine? YES - NO
  - a. If "Yes", please list:

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\_\_\_\_\_  
(Printed Name of Candidate)

\_\_\_\_\_  
(Signature of Candidate)

\_\_\_\_\_  
(Date)

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