MEDICAL CERTIFICATION FORM

Date of Exam: ____________________

Name: ____
(Last) (First) (Middle Initial)

SECTION I

Basic Insurance Coverage with: ______________________________________
(Name of Insurance Company)

Note: Attach a copy of the Front & Back of the Applicants Medical Insurance Card. (If the applicant is not covered under a parent (s) /guardian (s) insurance plan indicate by inserting the word none.)

____
(Address)

____
(Policy Number)

SECTION II

Please consider the following during the completion of this examination: The students ability to perform abdominal, chest, upper back, hamstring, and groin stretches, push-ups, sit-ups, side straddle hop, knee bends, running, and hiking, and environmental conditions such as, grass, dust, and being outdoors during hot humid days.

The above named individual has been examined by me as of this date and is considered to be physically fit to participate in vigorous military and sports activities, and is free of communicable disease.

Individual (is) (is not) currently taking medication/prescription. If so, please list: (Attach a separate sheet if needed)

1. ____________________ 2. ____________________ 3. ____________________

4. ____________________ 5. ____________________ 6. ____________________

Reason: ____

____

____

Name of Physician, Nurse Practitioner, or Physician Assistant: ______________________________
(Please Print)

Address: ____
Street City State Zip Code

PHYSICIANS STAMP:

REQUIRED

____
Signature of Physician, Nurse Practitioner, or Physician Assistant