**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-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**

1. Do you have high blood pressure or are you on blood pressure medication? **Yes No**
2. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication? **Yes No**
3. Do you have sugar diabetes? **Yes No**
4. Have you experienced episodes of rapid beating or fluttering of the heart? **Yes No**
5. Do you suffer from lower leg swelling of both legs? **Yes No**
6. Do you have difficulty breathing or have sudden breathing problems at night? **Yes No**
7. Do you have any personal history of metabolic disease (thyroid, renal, liver)? **Yes No**
8. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises? **Yes No**
9. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFT? **Yes No**
10. Have you ever been diagnosed with Sickle Cell Trait? **Yes No**

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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**

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Signature of Medical Practitioner Date

CNET Form 1533/106 (09-02)