

**NJROTC HEALTH RISK SCREENING QUESTIONNAIRE**

Cadet Name: \_\_\_\_\_ (Printed Name)

NJROTC Unit: **Bishop Kenny (NJROTC)** \_\_\_\_\_ High School

Date of your most recent pre-participation sports physical examination \_\_\_\_\_

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**Part A – TO BE COMPLETED BY THE CADET AND PARENT/GUARDIAN**

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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? \_\_\_\_\_
2. Have you been told **NOT** to participate in long distance runs, such as a 1.5-mile-run? \_\_\_\_\_
3. Have you been told **NOT** to do curl-ups or push-ups by a physician or other medical professional? \_\_\_\_\_
4. Do you exercise less than three times per week for at least thirty minutes? \_\_\_\_\_
5. Have you had any broken bones or a serious accident in the last three months? \_\_\_\_\_
6. Do you use tobacco of any kind? \_\_\_\_\_
7. Have you experienced chest, neck, jaw or arm discomfort while doing physical activity? \_\_\_\_\_
8. Do you have asthma or are you using an inhaler to aid in breathing? \_\_\_\_\_
9. Do you experience any shortness of breath with relatively low levels of exercise or exertion? \_\_\_\_\_
10. In the last month have you felt any chest pain at rest? \_\_\_\_\_
11. Do you have any known cardiac (heart) disease? \_\_\_\_\_
12. Do you think you are overweight? \_\_\_\_\_
13. Do you have dizzy/fainting spells, frequent headaches, or frequent back pains? \_\_\_\_\_
14. Have you ever experienced dehydration after strenuous physical exercise? \_\_\_\_\_
15. Are you currently under treatment by a physician or other medical practitioner? \_\_\_\_\_
16. Has your mother or sister died without any explanation or suffered a heart attack before the age of 55? \_\_\_\_\_
17. Has your father or brother died without any explanation or suffered a heart attack before the age of 45? \_\_\_\_\_
18. Do you have high blood pressure or are you on blood pressure medication? \_\_\_\_\_
19. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication? \_\_\_\_\_
20. Do you have sugar diabetes? \_\_\_\_\_
21. Have you experienced episodes of rapid beating or fluttering of the heart? \_\_\_\_\_
22. Do you suffer from lower leg swelling of both legs? \_\_\_\_\_
23. Do you have difficulty breathing or have sudden breathing problems at night? \_\_\_\_\_
24. Do you have any personal history of metabolic disease (thyroid, renal, liver)? \_\_\_\_\_
25. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises? \_\_\_\_\_
26. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFT? \_\_\_\_\_
27. Have you ever been diagnosed with Sickle Cell Trait? \_\_\_\_\_
28. Do you have a current prescription for epinephrine (or “epi” pen) for situational use? \_\_\_\_\_
29. Do you have any food allergies that require a special menu or special accommodations? \_\_\_\_\_

If you answered yes to any question, please continue to the second page.

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Cadet Signature	Date	Parent/Guardian Signature	Date
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Cadet Name: \_\_\_\_\_

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**Part B – TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER**

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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 :

Significant clinical history and/or current medication and treatment regimen of the above cadet: (Use reverse side if necessary)

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Recommended/released for participation in strenuous physical activities including the 1.5-mile-run and swimming laps?

YES    NO

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\_\_\_\_\_  
Signature of Medical Practitioner

\_\_\_\_\_  
Date