DAVE YOST
OHIO ATTORNEY GENERAL

Ohio Peace Officer Training Commission
Office 800-346-7682

Student Health Data

Name: ________________________ ________________________ __________________ Age:______ Sex: Male _____ Female_____
Last First Middle

School Name: ____ School Number: _______________________________

Commander Name: ______________________________________ Commander Email: ____

Do you have any physical or psychological limitations/injuries that might in any way restrict your full participation in physical activities during training?

_____ Yes _____ No If yes, please describe: ____

____

____ ______________________________
Student's Signature Date

This section to be completed by medical professional (medical doctor (MD), osteopath (DO), physician's assistant (PA), or certified nurse practitioner (CNP), licensed by the Ohio State Medical Board or the Ohio State Board of Nursing, or a neighboring state's equivalent, or a medical professional with the US Department of Veterans' Affairs.): This physical examination should ascertain any conditions which may preclude the student's ability to participate in, or which may be aggravated by, strenuous physical exercise. As a part of peace officer basic training, the student will engage in calisthenics, running, jumping, wrestling, unarmed self-defense, firearms, driving and other physically demanding exercises.

Height: _____ feet ______ inches Weight: _______ pounds Resting Pulse Rate: ______ beats per minute Blood Pressure: _____/ ______

Does the patient have a medical history of, or presently demonstrate symptoms of, any of the following?

Yes	No		Yes	No	
____	____	1. Uncorrected visual deficiency	____	____	9. Dizziness/Fainting
____	____	2. Major impairment of the senses	____	____	10. Back/Neck injury or recurrent pain
____	____	3. Asthma or Breathing difficulties	____	____	11. Pregnancy
____	____	4. Heart attack; Angina Pectoris	____	____	12. Communicable diseases
____	____	5. Stroke	____	____	13. Amputation/Prosthetic devices
____	____	6. Hemorrhage	____	____	14. Bone/joint injury or recurrent pain
____	____	7. Hypertension	____	____	15. Taking medication
____	____	8. Allergies _____________________	____	____	16. Under physician's continuing care

Please note any other condition(s) not listed above which may affect the student's participation. Also please explain each "Yes" response above, indicating the item number:

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As a result of my physical examination, I have determined that the student can, without limitation, safely function in all phases of strenuous physical training including, but not limited to, calisthenics, running, jumping, wrestling, unarmed self-defense, firearms, driving and a physical fitness assessment consisting of sit-ups, push-ups, and a timed 1.5 mile run.

____ ____
Signature of Medical Professional Printed/Typed Name with Title (MD, DO, PA or CNP)

___________________________ _________________ ____
License Number Issuing State Phone Number

____ ____
Address Date of Examination

____
City, State, Zip

***Please give completed form back to the student to return to the commander or send to the above noted commander's email address.**