

Allergies: _____

Meds: _____

**MEDICAL SCREENING FORM
SERE/CWEST TRAINING**

Part A: To be filled out by student

Name: (Last, First, MI) Rank/Rate SSN

Age Unit Weight Class Number

Circle YES or NO: Do you currently have or ever had

- | | | | | | |
|------------|-----------|---|------------|-----------|-------------------------|
| YES | NO | Temporary caps or fillings | YES | NO | Immersion/Trench Foot |
| YES | NO | Jaw Trouble | YES | NO | Frost Bite |
| YES | NO | Braces | YES | NO | High Blood Pressure |
| YES | NO | Implants | YES | NO | Heart Disease/Murmur |
| YES | NO | Crowns | YES | NO | Deep Vein Thrombosis |
| YES | NO | Maryland Bridge | YES | NO | Stroke/CVA |
| YES | NO | Retained Hardware (Dental)
(Ortho Screws, Pins, Plates) | YES | NO | Allergy to Medications |
| YES | NO | Shoulder Trouble | YES | NO | Allergy to Bee Stings |
| YES | NO | Fracture of the Neck or Back | YES | NO | Diabetes |
| YES | NO | Back Trouble | YES | NO | Lung Disease |
| YES | NO | Deformity of the Back | YES | NO | Shortness of Breath |
| YES | NO | Injury to the Hip, Knee, Ankle | YES | NO | Crohns Disease/IBS |
| YES | NO | Neurological Problems | YES | NO | GERD |
| YES | NO | Shingles | YES | NO | Ulcers/Gastritis |
| YES | NO | Heat Stroke | YES | NO | Kidney/Bile Duct Stones |
| YES | NO | Heat Exhaustion | YES | NO | Internal Med Condition |
| YES | NO | Hypothermia | YES | NO | Claustrophobia |
| YES | NO | Negative Life Experience in last year
(Death of family member, Training Mishap, Divorce) | | | |
| YES | NO | Have you seen a Doctor in the Last <u>90 days</u> for other than a Flight
Physical? | | | |
| YES | NO | Do you currently have a sore throat or cold? | | | |
| YES | NO | Are you currently taking any medications? | | | |
| YES | NO | Do you need to see a Flight Surgeon at this time? | | | |
| YES | NO | Do you need to see a Psychologist at this time? | | | |

Additional Comments: Explain all "YES" responses to the above questions.

Have you had in the past 180 days:

YES	NO	Pneumonia	YES	NO	Yellow Jaundice
YES	NO	Sprains/Strains	YES	NO	Hospitalization
YES	NO	Rupture Ear Drum/Baro Trauma	YES	NO	Surgery
YES	NO	Hernia	YES	NO	Fractured Bones

FEMALES ONLY:

YES	NO	Are you menstruating?
YES	NO	Currently taking birth control?
YES	NO	Could you be pregnant?

Additional Comments: Explain all "YES" responses to the above questions. List any medical concerns you may have about your SERE training.

I certify I have truthfully and completely answered all questions.

Signature

Date

Part B: To be filled out by the examining physician.

S:

O:

H:

E:

E:

N:

T:

NECK

HEART

LUNGS

ABDOMEN

MUSCLES/SKELETAL

NEUROLOGICAL

Additional comments and information:

A:

Student is physically qualified for SERE/CWEST training at this time. YES NO

P:

Examining physician:

Signature

Date

Stamp or printed information: