**HEALTH APPRAISAL FORM**

Last Name First Name MI DOB Grade

If your student has had a history of any of the following medical conditions please mark with an X and explain in full detail in the comments area any precautions we should take regarding the condition.

|  |  |  |  |
| --- | --- | --- | --- |
| Chicken Pox |   | Kidney Disease |   |
| Measles |   | Menstrual Concerns |   |
| German Measles |   | Orthopedic Problems |   |
| Mumps |   | Convulsions or Equivalent |   |
| Allergies |   | Neurological Disorder |   |
| Eye Problems |   | Emotional Problems |   |
| Hearing Problems |   | Accidents (Wetting) |   |
| Pulmonary Disease |   | Operations |   |
| Cardiac Disease |   | Hospitalizations |   |
| Thyroid Disorder |   | Other Problems |   |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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To the best of my knowledge

( ) My child is physically qualified to participate in the JROTC program.

( ) My child is physically qualified to participate in JROTC but with the following limitations:

( ) My child is not physically or otherwise qualified to participate in the JROTC program

Signature of Parent/Guardian: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_