**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_