COMBATIVES MASTER TRAINER COURSE
MEDICAL SCREENING FORM

Instructions – Fill in the information requested. If you have any condition that might be a source of concern or may be aggravated by your participation in this activity, indicate below:

NAME (Please print):_____**UNIT:**_____**CO:**_____

DODID: _____ **MAC LEVEL** _____**HEIGHT:**_____**WEIGHT:** _____

When was your last physical?_____(MM-DD-YYYY)

Current physical condition: **EXCELLENT / GOOD / FAIR / BELOW STANDARD**

Are you currently on profile? **Y / N** If yes, for what? _____

Did you require a waiver for vision to enter the military? **Y / N**

If so, why? _____

Have you ever had LASIK or any other eye surgery? **Y / N** If yes, when? _

Have you **EVER** been knocked unconscious? **Y / N**

If yes, When_____have you been cleared? **Y / N**

Have you undergone breast augmentation? **Y / N**

***** Have you been in contact with anyone that has Hepatitis? **Y / N**

If yes, date of HEP Screening done within 6 months of course: _____

***** ***Date of HIV screening done within 6 months of competition***: _____

(FEMALES ONLY) Are you pregnant or feel you may become pregnant? **Y / N**

Pregnancy test must be within 48 hrs. of competition. *Date test was administered*:_____

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Do you have, or have you had, any injuries in the following areas?

PART	NO	YES	*If Yes, explain*
1. Head			
2. Nose			
3. Jaw or teeth			
4. Facial Bones			
5. Neck			
6. Back			
7. Elbow			
8. Shoulder			
9. Headaches			
10. Dizziness			
11. Wrist			
12. Hand			
13. Arm			
14. Knee			
15. Ankle			
16. Foot			
17. Leg			
18. Kidney/Spleen			
19. Memory Loss			
20. Numbness			

Do you have any other injuries not listed above? If yes, provide details of the injury on the back of this sheet. If you answered "Yes" to any of the above items, please provide details of the incident on the back of this sheet.

I understand that under the provisions of 5 USC 552a, The Privacy Act of 1974, that it is prohibited to release any of the information contained in this file to agencies or individuals outside the U.S. Government without my consent. I also understand that I am under no obligation to authorize or allow such release for whatever purpose it deems appropriate or necessary; and should I withhold such authorization, the information will not be released to private third parties and no consequences of any kind will result.

PA/Physician Stamp & Signature:_____ **DATE:**_____

Student Signature: _____ **DATE:**_____

* *Hepatitis/ HIV screening must be completed prior to course. You must provide an IMR printout showing negative on both screenings.* *