*** ARNG WARRIOR TRAINING CENTER: RTAC MEDICAL SCREENING SHEET ***

1. NAME (LAST, FIRST, MI)	2. DATE OF BIRTH		3. AGE
4. SSN/DoD ID	5. HOME UNIT	6. SERVICE BRANCH (ARMY, ARNG, USAF, ETC.)	
7. GEOGRAPHICAL LOCATION FOR THE PAST 2 WEEKS (STATE/COUNTRY)	8. CLASS NUMBER	9. ROSTER NUMBER	

CHECK THE APPROPRIATE COLUMN FOR EACH QUESTION BELOW

Question		
10. HAVE YOU BEEN SEEN BY A HEALTHCARE PROVIDER FOR ANY REASON SINCE YOUR RANGER PHYSICAL?	YES	NO
11. DO YOU HAVE ANY CHRONIC MEDICAL AND/ OR ORTHOPEDIC CONDITION OF ANY TYPE, AND/OR PAST SURGERIES?	YES	NO
12. HAVE YOU RECENTLY STOPPED OR ARE CURRENTLY TAKING ANY MEDICATION (LAST 3 MONTHS)? IF SO, HOW LONG, AND WHAT FOR?	YES	NO
13. HAVE YOU EVER HAD ANY CORRECTIVE EYE SURGERY IN THE LAST 6 MONTHS? (EXAMPLE: LASIK, PRK, OR RK)	YES	NO
14. DO YOU HAVE ANY FALSE TEETH, PLATES, SCREWS, PIN, OR OTHER DEVICES IN YOUR BODY THAT YOU WERE NOT BORN WITH?	YES	NO
15. HAVE YOU EVER BEEN MEDICALLY DROPPED FROM RTAC, RANGER, RSLC OR ANY OTHER COURSE FOR ANY REASON?	YES	NO
16. DO YOU HAVE ANY ALLERGIES? (EXAMPLE: BEE STINGS, MEDICATION, ETC.) IF SO, WHAT REACTION DOES IT CAUSE?	YES	NO
17. HAVE YOU EVER BEEN DIAGNOSED WITH OR IDENTIFIED AS A HOT OR COLD WEATHER INJURY?	YES	NO
18. IN THE PAST 72 HOURS, HAVE YOU EXPERIENCED ANY NAUSEA, VOMITING, DIARRHEA, OR FEVER?	YES	NO

19. EXPLANATION OF ALL "***YES***" ANSWERS. GIVE ***DATES, NAMES OF MEDICAL PROVIDERS***, AND ***TREATMENT FACILITIES***, ***TREATMENT GIVEN***, AND ***CURRENT MEDICAL STATUS***.

20. UPON COURSE COMPLETION, WILL YOU BE ATTENDING THE NEXT RANGER SCHOOL CLASS?	YES	NO

21. **I HAVE READ THE QUESTIONS ABOVE AND ANSWERED THEM TO THE BEST OF MY KNOWLEDGE. BY SIGNING BELOW, I AM AFFIRMING I UNDERSTAND THAT IF ANY FALSE INFORMATION IS GIVEN, I CAN BE DISMISSED FROM THE ARNG WARRIOR TRAINING CENTER RANGER TRAINING ASSESSMENT COURSE AND AM SUBJECT TO DISCIPLINARY ACTION.**

A. SIGNATURE	B. DATE

PART 2. TO BE COMPLETED BY MEDICAL SCREENER

1	2	3	***PHYSICAL EXAM DOCUMENTATION***	FINAL
			Screener Initials on This Line	
			DD FORM 2807	
			3 DATE **<18 MONTHS**	
			1-9 ADMIN DATA + TOP OF EACH PAGE (NAME, SSN/DoD ID)	
			10-29 ALL "YES" EXPLAINED (14C MARKED "YES")	
			30B PA/NP/MD/DO/MC SIGNATURE	
			DD FORM 2808	
			1 DATE **<18 MONTHS**	
			2-16 ADMIN DATA + TOP OF EACH PAGE (NAME, SSN/DODID)	
			17- 42 CLINICAL EVALUATION	
			43 DENTAL CLASS (1 OR 2 ONLY)	
			48 BLOOD TYPE	
			53 HEIGHT	
			54 WEIGHT	
			56 TEMP (WNL)	
			57 PULSE <90	
			58 BP < 140/90	
			59 COLOR VISION (RED/GREEN) "PASS"	
			61 DISTANT VISION <20/100	
			63 NEAR VISION <20/100	
			72B VALSALVA	
			74 RANGER QUALIFIED (YES OR WAIVER IS REQUIRED)	
			76 PULHES (111111 OR WAIVER IS REQUIRED)	
			84 DENTIST SIGNATURE (DMD, DDS, DC)	
			82-86 MD/MC/DO SIGNATURE (ONLY ONE PROVIDER SIGNATURE NEEDED)	
			87 WAIVER APPROVAL ***FROM 4TH RTB ONLY*** (IF NEEDED)	

1	2	3	***SUPPORTING MEDICAL DOCUMENTATION*** (PRINTED)	FINAL
			Screener Initials on This Line	
			AUDIOGRAM (DD 2216E: H2/H3 NEED WAIVER)	
			5K 1K 2K 3K 4K 6K	
			<35 <35 <35 <45 <55 N/A	
			VACCINATIONS (OCT-APR ONLY)	
			H1NH/FLUMIST/FLU SHOT	
			URINALYSIS **<18 MONTHS**	
			SPECIFIC GRAVITY (1.005- 1.035)	
			PROTEIN NEGATIVE	
			GLUCOSE NEGATIVE	
			BLOOD NEGATIVE	
			FEMALES ONLY: HCG (NEW ORDER ONLY-NO PAST RESULTS)	
			COMPLETE BLOOD COUNT(CBC) **<18 MONTHS**	
			WHITE BLOOD COUNT (WBC) WNL	
			HEMATOCRIT PERCENTAGE (37-52)	
			HEMOGLOBIN 13.5-18.0 (FEMALE: 12.0-18.0)	
			PLATELETS WNL	
			HIV **<24 MONTHS**	
			NEGATIVE	
			SICKLE CELL/HGB SOLUBILITY (NO DATE REQUIREMENT)	
			NEGATIVE	
			AGE 35+: FASTING BLOOD SUGAR (FBS) **<18 MONTHS**	
			WNL	
			AGE 35+: FASTING LIPIDS **<18 MONTHS**	
			WNL	
			AGE 35+: ECG/EKG **<18 MONTHS**	
			WNL, SIGNED BY PHYSICIAN	
			AGE 40+: RECTAL (OCCULT BLOOD/GUAIAC) **<18 MONTHS**	
			NEGATIVE	

SCREENER NOTES:-

SCREENING STATUS: ☐ CLEAR TO TRAIN ☐ CCIR ☐ NOT CLEAR TO TRAIN (PER MO) **INITIAL SCREENER NAME (PRINT):**

UPDATED 07 SEP 2019: OROZCO, N