ANDY WILSON
OHIO ATTORNEY GENERAL

Ohio Peace Officer Training Academy
Office 800-346-7682

Student Health Data

Name: _____ Age:_____ Sex: Male ☐ Female ☐
Last First Middle

School Name: Scioto County Career Technical Center Course Number: _____

Do you have any physical or psychological limitations/injuries that might in any way restrict your full participation in physical activities during training?

☐ Yes ☐ No If yes, please describe: _____

_____

_____ _____
Student's Signature Date

This section to be completed by medical professional (medical doctor (MD), osteopath (DO), physician's assistant (PA), or certified nurse practitioner (CNP), licensed by the Ohio State Medical Board or the Ohio State Board of Nursing, or a neighboring state's equivalent, or a medical professional with the US Department of Veterans' Affairs.): This physical examination should ascertain any conditions which may preclude the student's ability to participate in, or which may be aggravated by, scenario based training. As a part of refresher training, the student may engage in calisthenics, running, jumping, wrestling, unarmed self-defense, firearms, driving and other physically demanding exercises.

Height: _____feet _____inches Weight: _____pounds Resting Pulse Rate: _____beats per minute Blood Pressure: _____/ _____

Does the patient have a medical history of, or presently demonstrate symptoms of, any of the following?

Yes	No		Yes	No	
☐	☐	1. Uncorrected visual deficiency	☐	☐	9. Dizziness/Fainting
☐	☐	2. Major impairment of the senses	☐	☐	10. Back/Neck injury or recurrent pain
☐	☐	3. Asthma or Breathing difficulties	☐	☐	11. Communicable diseases
☐	☐	4. Heart attack; Angina Pectoris	☐	☐	12. Amputation/Prosthetic devices
☐	☐	5. Stroke	☐	☐	13. Bone/joint injury or recurrent pain
☐	☐	6. Hemorrhage	☐	☐	14. Taking medication that may impair training
☐	☐	7. Hypertension	☐	☐	15.Under physician's continuing care
☐	☐	8. Allergies _____			

Please note any other condition(s) not listed above which may affect the student's participation. Also please explain each "Yes" response above, indicating the item number:

_____

_____

As a result of my physical examination, I have determined that the student can, without limitation, safely function in all phases of strenuous physical training including, but not limited to, running, jumping, wrestling, control and compliance, firearms, driving and scenario-based training.

_____ _____
Signature of Medical Professional Printed/Typed Name with Title (MD, DO, PA or CNP)

_____ _____ _____
License Number Issuing State Phone Number

_____ _____
Address Date of Examination

_____
City, State, Zip

- Please give completed form back to the student to be emailed to opotaregistration@ohioago.gov
- This medical clearance is valid for one (1) year from the date of examination unless the participant experiences a significant illness, injury, surgery, hospitalization or other medical condition that could affect safe participation.