



CONTACT INFORMATION

THIS FORM IS TO BE COMPLETED BY APPLICANT

Please fill out the following forms in their entirety. The contact information you provide will be used by Occupational Health Partners to contact you for further correspondence regarding medical information. It is imperative that all correspondence is responded to in a timely manner to ensure Vermont Police Academy attendance. **Failure to comply will result in disqualification from attending the Vermont Police Academy.**
PLEASE PRINT CLEARLY AND READ ALL INSTRUCTIONS

DATE:	DOB:
NAME: <div style="display: flex; justify-content: space-between; width: 100%;"> (LAST) (FIRST) (MI) </div>	
CELL NUMBER:	ALTERNATE PHONE:
NAME OF SPONSORING AGENCY:	
Please check the box that corresponds to the level you are applying for: <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;">LEVEL III RECRUIT <input type="checkbox"/></div> <div style="text-align: center;">LEVEL II RECRUIT <input type="checkbox"/></div> <div style="text-align: center;">WAIVER OFFICER <input type="checkbox"/></div> </div>	
NAME OF PHYSICIAN:	
NAME OF MEDICAL PRACTICE:	
ADDRESS OF MEDICAL PRACTICE:	
PHONE NUMBER OF MEDICAL PRACTICE:	



MEDICAL HISTORY

1/16

THIS FORM IS TO BE COMPLETED BY APPLICANT

NAME: _____

DOB: _____

Please answer the following questions to the best of your ability.

If you answer yes to any questions please include the following: **Date, Severity, Treating physician or facility and any other pertinent information.**

Please attach additional paperwork if more room is needed. All questions need to be answered to ensure accurate evaluations.

HAVE YOU EVER HAD: <i>(Please select the appropriate checkbox & answer all questions)</i>			
1	Asthma or Wheezing	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
2	A Heart Murmur	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
3	"Leaky Heart" or abnormal heart valves	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
4	Fainting Spells	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
5	Chest Pain upon Exertion	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
6	Fast Heart Beat	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:



MEDICAL HISTORY

2/16

NAME: _____

DOB: _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*

7	High Blood Pressure	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
8	A Stroke	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
9	Shortness of breath on normal exertion	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
10	Shortness of breath at night or when lying down	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
11	Swelling of both feet or ankles	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
12	An abnormal electrocardiogram (EKG)	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
13	A "coronary" or "heart attack"	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
14	"Angina Pectoris" (Chest pain)	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
15	Heart disease or heart trouble	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:



MEDICAL HISTORY

3/16

NAME: _____

DOB: _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*

16	History of Lyme disease	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
17	Persistent numbness or weakness in the hands or feet	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
18	History of an eating disorder or a 25 pound weight gain or loss	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
19	Head injury with a loss of consciousness or a diagnosis of a concussion.	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
20	Leg pain on walking	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
21	Serious injury	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
22	Backaches	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
23	Back Injury	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
24	Worn back brace	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:



MEDICAL HISTORY

NAME: _____

DOB: _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*

25	Varicose veins	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
26	History of significant broken bones, muscle,	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
27	Pneumonia	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
28	Tuberculosis	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
29	Emphysema	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
30	Chronic lung disease	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
31	Abnormal chest x-ray	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
32	Cough up blood	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
33	Chronic cough or coughing up sputum frequently	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:



MEDICAL HISTORY

NAME: _____

DOB: _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*

34	Allergies	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
35	Bleeding or bruising tendencies	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
36	Peptic ulcer of stomach or duodenal ulcer	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
37	Polyps (growths) in stomach or intestine	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
38	Ulcerative colitis	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
39	Gall bladder trouble	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
40	Liver trouble	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
41	Stomach or intestinal trouble	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
42	Kidney or bladder trouble	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:



MEDICAL HISTORY

NAME: _____

DOB: _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*

43	Prostate trouble or difficulty urinating	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
44	Gout	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
45	Arthritis or rheumatism	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
46	Abnormal urine	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
47	Glandular problems or disease	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
48	Diabetes	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
49	Treatment for anxiety or depression	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
50	Disabling disease	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
51	Received workman's compensation and reason	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:



MEDICAL HISTORY

NAME: _____

DOB: _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*

52	Rheumatic fever or Inflammatory Rheumatism	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
53	Phlebitis—inflammation of a vein	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
54	Hernia	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
55	Sickle cell anemia	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
56	Anemia	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
57	Cancer of any type, Including skin	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
58	Other major illnesses or abnormalities	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:

FOR ALL APPLICANTS: Have you ever worked at a job or hobby where you were exposed to the following:
(Please select the appropriate checkbox & answer all questions)

59	Asbestos	YES: NO:	EXPLAIN:
-----------	----------	-------------	----------



MEDICAL HISTORY

NAME: _____

DOB: _____

FOR ALL APPLICANTS: Have you ever worked at a job or hobby where you were exposed to the following:
(Please select the appropriate checkbox & answer all questions)

60	Chemicals	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
61	Dust (such as wood, leather, heavy metals)	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
62	Dyes	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
63	X-rays (i.e. x-ray tech.)	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
64	Solvents or petroleum products	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE: *(Please answer where appropriate)*

65	Was your exposure indoors?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
66	Are you currently exposed to any of the materials listed above?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:

FOR WOMEN ONLY: *(Please answer when appropriate)*

67	Missed period for more than three months (not including pregnancy)?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
-----------	---	---	----------



MEDICAL HISTORY

NAME: _____

DOB: _____

FOR MEN ONLY: *(Please answer when appropriate)*

68	Have you had an undescended testicle at any time in your life? If yes, was this corrected?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
-----------	--	---	----------

69	Has your doctor ever told you that your prostate was enlarged?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	EXPLAIN:
-----------	--	---	----------

ADDITIONAL INFORMATION

70	Do you smoke?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	AMOUNT: HOW LONG HAVE YOU BEEN SMOKING:
-----------	---------------	---	--

71	Are you an ex-smoker?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	IF SO, THEN WHEN DID YOU QUIT:
-----------	-----------------------	---	--------------------------------

72	Are you currently taking medication?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	IF YES, PLEASE LIST:
-----------	--------------------------------------	---	----------------------

73	Have you ever taken steroids?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	IF YES, PLEASE EXPLAIN:
-----------	-------------------------------	---	-------------------------

74	Have you ever been treated for a seizure disorder?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	IF YES, PLEASE EXPLAIN:
-----------	--	---	-------------------------



FAMILY HISTORY

NAME: _____

DOB: _____

Please answer the following questions to the best of your ability.

Has any blood relative had cancer, heart disease or diabetes?

By blood relatives we mean: mother, father, daughters, sons, sisters, brothers, sister’s children, brother’s children, mother’s sisters and brothers, mother’s mother and father, father’s sisters and brothers, father’s mother and father.

CONDITION		WHAT IS THEIR RELATIONSHIP TO YOU?	WHAT WAS THEIR AGE AT DIAGNOSIS?
75	Diabetes		
76	Cancer		
77	High blood pressure		
78	Heart disease		
79	Glaucoma		
80	Stroke		
81	Polyps		
82	Aneurysm (cerebral, thoracic, abdominal, femoral)		



FAMILY HISTORY

NAME: _____

DOB: _____

83	Have any of these family members died from any of these conditions before their 60th birthday?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	IF YES EXPLAIN:
84	Have you prepared yourself for Physical Assessment by participating in any form of exercise program?	YES: <input type="checkbox"/> NO: <input type="checkbox"/> PARTIALLY: <input type="checkbox"/>	EXPLAIN:

I understand that information on this form will be provided to the physician designated by the Criminal Justice Training Council (CJTC) for review prior to my acceptance to basic training. This review is completed to ensure that I am physically able and suited to complete the rigorous physical requirements of basic training. This form and any subsequent medical information gathered by the CJTC during my screening and subsequent basic training will be retained for three (3) years from the date on which I complete basic training, and will then be destroyed. These records and this information will only be used for the stated purpose and will be kept confidential unless disclosure is compelled by legal process. My signature indicated that I acknowledge and agree to the terms of this application.

I hereby certify that this personal medical history questionnaire contains no false information and is complete to the best of my knowledge.

SIGNATURE: _____

DATE: _____



PHYSICAL EXAMINATION

NAME: _____

DOB: _____

The following is to be completed by a physician. If the physician has questions regarding the physical requirements of attending Basic Training, they can contact the Academy’s Training Staff at (802) 483-6228.

1	General	Speech Mood:	COMMENTS:
2	Vital Signs	Blood Pressure: Systolic _____ Diastolic _____ Pulse Rate: Regular _____ Irregular _____ Temperature: _____	
3	General Appearance (Place an “x” to the right of the words that apply)	Slender: <input type="checkbox"/> Medium: <input type="checkbox"/> Stout: <input type="checkbox"/> Obese: <input type="checkbox"/> Erect: <input type="checkbox"/> Drooped: <input type="checkbox"/>	
4	Bone Frame	Heavy <input type="checkbox"/> Medium: <input type="checkbox"/> Light: <input type="checkbox"/>	
5	Weight _____	Height _____	BMI _____
6	Waist Circumference at umbilicus: _____ inches		
7	HEENT : A physical examination concerning the head, eyes, ears, nose and throat:		



PHYSICAL EXAMINATION

13/16

NAME: _____

DOB: _____

8	Vision	Right Eye: _____ / _____ Left Eye: _____ / _____ Color Perception (Ishihara): _____	Corrected: _____ / _____ Corrected: _____ / _____ _____
9	Diseases	Eyes : _____ Ear : _____ Nose : _____ Throat: _____	
10	Hearing (Basic Audiogram) <i>Air Conduction Test</i> <i>*Attach Graph</i>	<input type="checkbox"/> Hearing within normal limits <input type="checkbox"/> Hearing outside normal limits <input type="checkbox"/> No follow up needed <input type="checkbox"/> Needs follow up prior to work placement Is their level of impairment a risk in this profession? Y <input type="checkbox"/> N <input type="checkbox"/>	
11	Mouth and Gums	COMMENTS:	
12	Dentition:	Excellent Repair: <input type="checkbox"/> Good Repair: <input type="checkbox"/> Poor Repair: <input type="checkbox"/>	
13	Respiratory System:	Breath Sounds: _____	
14	Cardiovascular System :	Heart Sounds: _____ Peripheral Edema: _____ Varicose Veins: _____	
15	Evidence of Bruits or inefficiencies	Carotid: _____ Radial: _____ Abdominal: _____ Femoral: _____	



PHYSICAL EXAMINATION

NAME: _____

DOB: _____

16	Abdominal Digestive System:	Bowel Sounds: _____ Tenderness: _____ Masses: _____ Abdominal walls weakness or hernia: _____ _____
17	Musculoskeletal (Abnormalities of bones, joints, and muscles—strength, ligament instability)	Neck and Back: _____ Upper Extremities: _____ Lower Extremities: _____
18	Nervous System	Reflexes: _____ Sensory: _____ Balance/Proprioception: _____
19	Integumentary System:	Rashes: _____ Infections: _____
20	Lymphatic System:	Lymphadenopathy:
21	Genito-urinary System:	Varicocele: _____ Hernia: _____
22	Urinalysis:	Sp. Gr: _____ Protein: _____ Blood: _____ Glucose: _____
23	Remarks:	



IMMUNIZATIONS

NAME: _____

DOB: _____

Immunizations: Write in the month, day and year received OR attach a copy of the most current immunization record.

Hepatitis B	1	2	3		
Tdap	1				
Td	1	2			
Polio	1	2	3	4	
Pneumococcal	1	2	3	4	5
Hepatitis A	1	2	3		
MMR	1	2			
Varicella	1	2	DATE OF DISEASE		
Meningococcal	1	2			
HPV	1	2	3		
Influenza	1	2	3	4	5
Other: _____					



FOR MEDICAL PROFESSIONAL

NAME: _____

DOB: _____

I certify that I have carefully examined the applicant named herein and have correctly recorded the results of the examination, and that, to the best of my knowledge and belief, he/she IS _____, IS NOT _____, mentally and physically qualified for attendance in the basic training program at the Vermont Police Academy.

Date: _____

Examining Medical Personnel:*** _____

*****PER THE ACADEMY PHYSICIAN:**

This examination must be done by a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician’s Assistant (PA) or an Advanced Practice Registered Nurse (APRN). If this examination was done by a PA, a supervising physician **MUST** also sign this form.

Supervising Physician (if applicable): _____

Name of Medical Practice: _____

Phone: _____

Address: _____

Comments:



MEDICAL HISTORY RELEASE FORM

THIS FORM IS TO BE COMPLETED BY APPLICANT

Please fill out the following form in its entirety. This form will permit Occupational Health Partners to speak with medical professionals who provided care to you previously. Please note, Occupational Health will not contact another health professional before speaking to you (the student) first. It is imperative that correspondence is timely regarding medical history.

Patient Name:	Date of Birth
Address:	Phone #:
<input type="checkbox"/> Release my medical records TO :<u>Occupational Health Partners</u> <input type="checkbox"/> Release my medical records FROM (current provider): _____	
Purpose of disclosure: Law Enforcement Training	Primary Care Phone: Primary Care Fax:
Primary Care Address:	Primary Care Email:
INFORMATION REQUESTED /TO BE RELEASED: <input type="checkbox"/> Initial Examination: <input type="checkbox"/> Office visit notes <input type="checkbox"/> Lab Results <input type="checkbox"/> Imaging and Imaging Reports <input type="checkbox"/> Entire Record	<input type="checkbox"/> Immunizations: <input type="checkbox"/> Drug Screen Results: <input type="checkbox"/> Other:
CONFIDENTIAL INFORMATION AUTHORIZATION: I understand that any information released is confidential and protected by law. This law prohibits further disclosure of this information without specific written consent of the patient.	
Patient signature: _____ <i>(or Authorized Legal Representative)</i> Witness: _____	Date: _____



MEDICAL HISTORY UPDATE FORM

THIS FORM IS TO BE COMPLETED BY APPLICANT

Please fill out the following form in its entirety. Include any updated medical information since your medical history form was completed. All significant injury, illness or surgeries that occur after the initial exam is complete but before Basic Training starts, must be disclosed to the Academy in writing and prior to Day 1 of training at the Police Academy. Please attach extra sheet of paper if needed.

Name:	Date of Birth
Address:	Phone #:
Since your medical release form was completed, did you experience any significant injury? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe _____	
Since your medical release form was completed, did you experience any significant illness? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe _____	
Since your medical release form was completed, did you experience any significant Surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe _____	
List where, when, and medical professional seen when you were treated for an injury, illness, and/or surgery: 	
CONFIDENTIAL INFORMATION AUTHORIZATION: I understand that any information released is confidential and protected by law. This law prohibits further disclosure of this information without specific written consent of the patient.	
Signature: _____ <i>(or Authorized Legal Representative)</i>	Date: _____
Witness: _____	