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: (LAST) (FIRST) (MI)	
CELL NUMBER:	ALTERNATE PHONE:
NAME OF SPONSORING AGENCY:	
Please check the box that corresponds to your level: LEVEL III RECRUIT ☐ LEVEL II RECRUIT ☐ WAIVER OFFICER ☐	
NAME OF PHYSICIAN:	
NAME OF MEDICAL PRACTICE:	
ADDRESS OF MEDICAL PRACTICE:	
PHONE NUMBER OF MEDICAL PRACTICE:	

MEDICAL HISTORY

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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: *(Please select the appropriate checkbox & answer all questions)*			
1	Asthma or Wheezing	YES: ☐ NO: ☐	EXPLAIN:
2	A Heart Murmur	YES: ☐ NO: ☐	EXPLAIN:
3	"Leaky Heart" or ab-normal heart valves	YES: ☐ NO: ☐	EXPLAIN:
4	Fainting Spells	YES: ☐ NO: ☐	EXPLAIN:
5	Chest Pain upon Exertion	YES: ☐ NO: ☐	EXPLAIN:
6	Fast Heart Beat	YES: ☐ NO: ☐	EXPLAIN:

MEDICAL HISTORY

NAME: _____ **DOB:** _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*			
7	High Blood Pressure	YES: ☐ NO: ☐	EXPLAIN:
8	A Stroke	YES: ☐ NO: ☐	EXPLAIN:
9	Shortness of breath on normal exertion	YES: ☐ NO: ☐	EXPLAIN:
10	Shortness of breath at night or when lying down	YES: ☐ NO: ☐	EXPLAIN:
11	Swelling of both feet or ankles	YES: ☐ NO: ☐	EXPLAIN:
12	An abnormal electrocardiogram (EKG)	YES: ☐ NO: ☐	EXPLAIN:
13	A “coronary” or “heart attack”	YES: ☐ NO: ☐	EXPLAIN:
14	“Angina Pectoris” (Chest pain)	YES: ☐ NO: ☐	EXPLAIN:
15	Heart disease or heart trouble	YES: ☐ NO: ☐	EXPLAIN:

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MEDICAL HISTORY

NAME: _____ **DOB:** _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*			
16	History of Lyme disease	YES: ☐ NO: ☐	EXPLAIN:
17	Persistent numbness or weakness in the hands or feet	YES: ☐ NO: ☐	EXPLAIN:
18	History of an eating disorder or a 25 pound weight gain or loss	YES: ☐ NO: ☐	EXPLAIN:
19	Head injury with a loss of consciousness or a diagnosis of a concussion.	YES: ☐ NO: ☐	EXPLAIN:
20	Leg pain on walking	YES: ☐ NO: ☐	EXPLAIN:
21	Serious injury	YES: ☐ NO: ☐	EXPLAIN:
22	Backaches	YES: ☐ NO: ☐	EXPLAIN:
23	Back Injury	YES: ☐ NO: ☐	EXPLAIN:
24	Worn back brace	YES: ☐ NO: ☐	EXPLAIN:

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MEDICAL HISTORY

NAME: _____ **DOB:** _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*			
25	Varicose veins	YES: ☐ NO: ☐	EXPLAIN:
26	History of significant broken bones, muscle,	YES: ☐ NO: ☐	EXPLAIN:
27	Pneumonia	YES: ☐ NO: ☐	EXPLAIN:
28	Tuberculosis	YES: ☐ NO: ☐	EXPLAIN:
29	Emphysema	YES: ☐ NO: ☐	EXPLAIN:
30	Chronic lung disease	YES: ☐ NO: ☐	EXPLAIN:
31	Abnormal chest x-ray	YES: ☐ NO: ☐	EXPLAIN:
32	Cough up blood	YES: ☐ NO: ☐	EXPLAIN:
33	Chronic cough or coughing up sputum frequently	YES: ☐ NO: ☐	EXPLAIN:

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MEDICAL HISTORY

NAME: _____ **DOB:** _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*			
34	Allergies	YES: ☐ NO: ☐	EXPLAIN:
35	Bleeding or bruising tendencies	YES: ☐ NO: ☐	EXPLAIN:
36	Peptic ulcer of stomach or duodenal ulcer	YES: ☐ NO: ☐	EXPLAIN:
37	Polyps (growths) in stomach or intestine	YES: ☐ NO: ☐	EXPLAIN:
38	Ulcerative colitis	YES: ☐ NO: ☐	EXPLAIN:
39	Gall bladder trouble	YES: ☐ NO: ☐	EXPLAIN:
40	Liver trouble	YES: ☐ NO: ☐	EXPLAIN:
41	Stomach or intestinal trouble	YES: ☐ NO: ☐	EXPLAIN:
42	Kidney or bladder trouble	YES: ☐ NO: ☐	EXPLAIN:

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MEDICAL HISTORY

NAME: _____ **DOB:** _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*			
43	Prostate trouble or difficulty urinating	YES: ☐ NO: ☐	EXPLAIN:
44	Gout	YES: ☐ NO: ☐	EXPLAIN:
45	Arthritis or rheumatism	YES: ☐ NO: ☐	EXPLAIN:
46	Abnormal urine	YES: ☐ NO: ☐	EXPLAIN:
47	Glandular problems or disease	YES: ☐ NO: ☐	EXPLAIN:
48	Diabetes	YES: ☐ NO: ☐	EXPLAIN:
49	Treatment for anxiety or depression	YES: ☐ NO: ☐	EXPLAIN:
50	Disabling disease	YES: ☐ NO: ☐	EXPLAIN:
51	Received workman's compensation and reason	YES: ☐ NO: ☐	EXPLAIN:

7/16

MEDICAL HISTORY

NAME: _____ **DOB:** _____

HAVE YOU EVER HAD: *(Please select the appropriate checkbox & answer all questions)*			
52	Rheumatic fever or Inflammatory Rheumatism	YES: ☐ NO: ☐	EXPLAIN:
53	Phlebitis—inflammation of a vein	YES: ☐ NO: ☐	EXPLAIN:
54	Hernia	YES: ☐ NO: ☐	EXPLAIN:
55	Sickle cell anemia	YES: ☐ NO: ☐	EXPLAIN:
56	Anemia	YES: ☐ NO: ☐	EXPLAIN:
57	Cancer of any type, Including skin	YES: ☐ NO: ☐	EXPLAIN:
58	Other major illnesses or abnormalities	YES: ☐ NO: ☐	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:

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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: ☐ NO: ☐	EXPLAIN:
61	Dust (such as wood, leather, heavy metals)	YES: ☐ NO: ☐	EXPLAIN:
62	Dyes	YES: ☐ NO: ☐	EXPLAIN:
63	X-rays (i.e. x-ray tech.)	YES: ☐ NO: ☐	EXPLAIN:
64	Solvents or petroleum products	YES: ☐ NO: ☐	EXPLAIN:
IF YOU ANSWERED "YES" TO ANY OF THE ABOVE: *(Please answer where appropriate)*			
65	Was your exposure indoors?	YES: ☐ NO: ☐	EXPLAIN:
66	Are you currently exposed to any of the materials listed above?	YES: ☐ NO: ☐	EXPLAIN:
FOR WOMEN ONLY: *(Please answer when appropriate)*			
67	Missed period for more than three months (not including pregnancy)?	YES: ☐ NO: ☐	EXPLAIN:

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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: ☐ NO: ☐	EXPLAIN:
69	Has your doctor ever told you that your prostate was enlarged?	YES: ☐ NO: ☐	EXPLAIN:
ADDITIONAL INFORMATION			
70	Do you smoke?	YES: ☐ NO: ☐	AMOUNT: HOW LONG HAVE YOU BEEN SMOKING:
71	Are you an ex-smoker?	YES: ☐ NO: ☐	IF SO, THEN WHEN DID YOU QUIT:
72	Are you currently taking medication?	YES: ☐ NO: ☐	IF YES, PLEASE LIST:
73	Have you ever taken steroids?	YES: ☐ NO: ☐	IF YES, PLEASE EXPLAIN:
74	Have you ever been treated for a seizure disorder?	YES: ☐ NO: ☐	IF YES, PLEASE EXPLAIN:

10/16

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		

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FAMILY HISTORY

NAME: _____ **DOB:** _____

83	Have any of these family members died from any of these conditions before their 60th birthday?	YES: ☐ NO: ☐	IF YES EXPLAIN:
84	Have you prepared yourself for Physical Assessment by participating in any form of exercise program?	YES: ☐ NO: ☐ PARTIALLY: ☐	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: _____

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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: ☐ Medium: ☐ Stout: ☐ Obese: ☐ Erect: ☐ Drooped: ☐	
4	**Bone Frame**	Heavy ☐ Medium: ☐ Light: ☐	
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

NAME: _____ **DOB:** _____

8	**Vision**	Right Eye: _____ / _____ Left Eye: _____ / _____ Color Perception (Ishihara):	Corrected: _____ / _____ Corrected: _____ / _____ _____
9	**Diseases**	Eyes : _____ Ear : _____ Nose : _____ Throat: _____	
10	**Hearing** (whisper test)	Right Ear: _____ Left Ear: _____	
11	**Mouth and Gums**	COMMENTS:	
12	**Dentition:**	Excellent Repair: ☐ Good Repair: ☐ Poor Repair: ☐	
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:**	

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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 #:
I hereby authorize the medical offices of Occupational Health Partners: ☐ **Release my medical records TO : _____** ☐ **Release my medical records FROM : _____**	
Purpose of disclosure:	Phone: Fax:
Address:	Email:
INFORMATION REQUESTED /TO BE RELEASED: ☐ Initial Examination: ☐ Office visit notes ☐ Lab Results ☐ Imaging and Imaging Reports ☐ Entire Record	☐ Immunizations: ☐ Drug Screen Results: ☐ 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: _____ *(or Authorized Legal Representative)* Witness: _____	Date: _____