

C.A.R.T.A.

(CAPITAL AREA REGIONAL TRAINING ACADEMY)

Health Form

A PHYSICIAN MUST COMPLETE THIS FORM BEFORE AN APPLICANT WILL BE ALLOWED TO ENTER THE ACADEMY. (Must be within 6 months of Academy date.)

NAME: _____ DOB: _____

DEPARTMENT: _____ PHONE: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

Can the listed person participate in the following strenuous physical activities during the Basic Academy?
(Check One for Each Activity)

1.5 Mile Run	Yes ___ No ___	Handcuffing Exercise	Yes ___ No ___
Sit-Ups	Yes ___ No ___	Takedown Handcuffing	Yes ___ No ___
Firearms Training	Yes ___ No ___	Punch Blocking Exercise	Yes ___ No ___
Aerobics Exercise	Yes ___ No ___	Weapon Retention Tech.	Yes ___ No ___
Kicking Exercise	Yes ___ No ___	Down Fighting	Yes ___ No ___
Escape Exercise	Yes ___ No ___	Other Strenuous Activities	Yes ___ No ___
Push-ups	Yes ___ No ___		

If the answer to any of the above is No, List and explain the physical condition(s) precluding the participating:

List Severe Allergies: (bee stings, latex (gloves) etc. _____

PHYSICIAN'S EVALUATION AND RECOMMENDATIONS: In your opinion can this applicant participate in the above exercise?

Physician's Signature _____ Date _____

Type or Print Physicians Name and Address _____

Applicant's Signature _____ Date _____

Departmental Administrator's signature and Title _____ Date _____

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY: _____

Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____