

Check One

<input type="checkbox"/>	QUALIFIED	PRINT: Healthcare Provider (MD, PA, NP, IDC, or HM)	PHONE
<input type="checkbox"/>	NOT QUALIFIED	SIGNATURE: Healthcare Provider (MD, PA, NP, IDC, or HM)	DATE

Medical (MD, PA, NP, IDC) Remarks:

Note: Part 2 can be completed either prior to check in to the training site by the appropriate health care provider or at the training site by the supporting HM. Students must inform the HM of any changes in medical status upon arrival at training site.

[PART – 2] Answer each question by placing an “X” in the appropriate column.

	YES	NO	N/A	QUESTION
1				Are you on limited/light duty or have you had a tooth extracted within the past 72 hours?
2				Have you tested positive for Sickle Cell Trait or G6PD Deficiency?
3				Do you have any issues with your vision that is not corrected with lenses?
4				Do you have active dermatitis or severe acne?
5				Do you have any food or environmental allergies (to include wasp/bee stings, ant bites, nuts, latex, iodine, chlorine, pepper, shellfish, etc.)?
6				Do you have an epinephrine injector (EpiPen) requirement? If yes, EpiPen must be within expiration date and present to train.
7				Do you have a color vision deficit?
8				Do you have an inhaler requirement? If yes, inhaler must be within expiration date and present to train.
9				Do you become anxious when in tight, dark spaces or when you wear a mask for prolonged periods?

PRINT/SIGNATURE of Healthcare Provider: _____ **DATE** _____

Healthcare Provider Remarks:

Note: Part 3 is to be completed at the training site. Students arriving at the training site who answer “YES” to the below questions may be disqualified from participation in the high-risk event at the discretion of the Training Site Authority. Before commencing high risk training, the training activity shall review the form and ascertain from the student whether anything has changed.

[PART – 3] Answer each question by placing an “X” in the appropriate column.

YES	NO	QUESTION
		Have you consumed any alcoholic beverages within the last 12 hours of the high-risk event?
		Did you sleep less than 4 hours previous to the high-risk event?
		Has anything changed since the date of initial screening?

APPROVED TO TRAIN (Circle Appropriate Response)

YES **NO** **SIGNATURE: Training Site Authority** **DATE**

After completion and review, this form will be stored in a locked container at all times to ensure privacy. This form shall be destroyed no later than 30 days after trainee has graduated. The screening sheet is valid for **45 Days** after the healthcare provider signs the screening sheet. **Note: Training Site Authority signature** is defined as that designated through formal letter, command instruction, or executive suite signature (CO, Officer in Charge, Executive Officer).

Privacy Act Statement

- Authority:** U.S.C. 301, Departmental Regulations and E.O. 9397
- Principal Purpose:** To assist in determining physical suitability for participation in high risk training.
- Routine Use:** The blanket routine uses that appear at the beginning of the department of the Navy compilation in the Federal Register apply.
- Mandatory or voluntary disclosure and effect on individual not providing information:** Providing the information is voluntary; however, failure to do so may preclude participation in high risk training.