Medical Examination Package

This medical examination package is prepared for the Police Basic Training Academy Recruit. All enclosures and forms should be read carefully and then properly completed. Forms must be returned to the Suburban Law Enforcement Academy before the starting date of the course.

Attention: It is the employing agency that sets the minimum employment health standards.

Form: I. Medical History Background – To be completed by the training applicant.

II. Medical Examination – To be completed and signed by the examining physician.

III. Physician’s Conclusion – To be completed by examining physician, and when appropriate, by the training applicant and his/her agency head.

IV. General Information for Physical Training Areas – To be signed by the Training applicant.

THE ENTIRE MEDICAL EXAMINATION PACKAGE, INCLUDING ALL THE ATTACHED FORMS, MUST BE COMPLETED, SIGNED (AS APPROPRIATE), AND RETURNED TO THE SUBURBAN LAW ENFORCEMENT ACADEMY PRIOR TO THE CLASS START DATE.
Name of Officer:__________________________________________________________

Department/Agency:

Age:_________ Height:_________ Weight:_________ Sex:_________

TO EXAMINATION PHYSICIAN:

The Suburban Law Enforcement Academy at College of DuPage, under the auspices of the Illinois Law Enforcement Training and Standards Board, conducts a 400 hour training program for police recruits. In conjunction with the overall program, there is a block of 40 hours devoted to physical training that includes the following:

1. Stretching
2. Sit-ups
3. Push-ups
4. Running
5. Hands-on Defensive Tactics Training
   (includes arrest scenarios)

Should there be any questions concerning the program, feel free to contact the Academy Director at 630-942-2677.

I certify that I have examined this Probationary Officer and that, on the basis of the examination, and find that in my professional opinion can perform all such physical activities normally associated with the Basic Law Enforcement Training Course, find no reason which would make it medically inadvisable for this Officer to participate in the above scheduled activities.

Physician’s Signature:____________________________________________________

Physician’s Name:________________________________________________________
   (print or type)

Physician’s Address:________________________________________________________
   ________________________________________________________________

Physician’s Telephone:______________ Date of Exam:_____________
### FORM I – MEDICAL HISTORY FORM

**SECTION I**

(To be completed by the training applicant, please type or print)

**Date:** __________

**Name:** __________________________________________

(____) (____) (____)

**Age:** __________

**Birth Date:** __________

**Address:** _______________________________________

(____) (____) (____)

**Phone:** __________

**Department/Employer:** __________________________

**City:** __________

Note: The Training Applicant must be in good physical condition, capable of sustained exertion and regular participation in activities involving the use of firearms, physical training and defensive tactics. This is to be confirmed through a complete physical examination by a medical doctor of the employing agency.

**INSTRUCTIONS:** Please answer all questions and comment on all positive answers.

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<th>Have you ever had?</th>
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<td>Allergies: explain</td>
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<td>German Measles</td>
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<td>Cancer: explain</td>
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<td>Diabetes</td>
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<td>Skin Problem</td>
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<td><strong>PHYSICAL LIMITATIONS</strong></td>
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<td>Dizziness/Fainting</td>
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<td>Orthopedic explain</td>
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<td>Gyne Problem: explain</td>
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<td><strong>EMOTIONAL/MENTAL HEALTH</strong></td>
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<td>Ulcers</td>
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</table>
1. Are you receiving any medical treatment that requires continuing care and/or treatment? If yes, explain.

____________________________________________________________________

____________________________________________________________________

2. List the medications you take regularly:

____________________________________________________________________

____________________________________________________________________

3. Have you ever been advised against any physical exercise? If yes, explain.

____________________________________________________________________

____________________________________________________________________

4. Have you been treated for recurring back/neck problems? If yes:
   Specific Problem: ________________________________________________
   Date of Treatment: _____________________________________________

5. Do you have any difficulty hearing or understanding what others say? If yes, explain.

____________________________________________________________________

____________________________________________________________________

6. Lifestyle:
   Do you exercise regularly? □ yes □ no   How much? ________________
   Do you smoke: □ yes □ no   What? ______________   How much? __________
   Do you drink, including beer? □ yes □ no   How much? ______________

7. Date of last dental examination: ________________

8. It is advisable that all females have a yearly gynecological exam.
   Date of last exam: ________________
A. How would you rate the physical activity of yourself as compared to others of the same age and sex? Include both leisure and work activities.

☐ EXTREMELY INACTIVE ☐ SOMEWHAT ACTIVE
☐ INACTIVE ☐ ACTIVE
☐ SOMEWHAT INACTIVE ☐ EXTREMELY ACTIVE

B. For the last three months, which of the following activities have you regularly performed?

1) Walking, running or jogging.
   ☐ Yes  a. How many workouts/week? ________
   b. How many miles/workout? ________
   c. What is your average time/mile? ________

2) Playing a strenuous racket sport (tennis, paddleball, etc.).
   ☐ Yes  a. How many hours/week? ________
   ☐ No

3) Riding a bicycle.
   ☐ Yes  a. How many miles/week? ________
   ☐ No

4) Swimming.
   ☐ Yes  a. How many miles/week? ________
   ☐ No

This medical questionnaire has been completed and all answers or responses are accurate and reliable to the best of my knowledge. I am aware of the physical requirements of my professional program and certify that the above medical history is current and accurate.

RECRUIT SIGNATURE:______________________________________________________

DATE:____________________
Illinois Law Enforcement Training and Standards Board requires “Each applicant must submit a properly endorsed medical examination form at the time of application. The applicant must have received a medical examination prior to the date on which the respective Basic Training course begins.”

Training Applicants Name: ____________________________ SS #: __________

Address of Examining Physician: __________________________________________

City: ______________________ Phone: ______________

Date of Exam: ______________

CLINICAL EVALUATION: _______________________________________________

Instructions: Check each item in the appropriate column. Please describe every abnormality in detail and provide explanatory information and/or comments.

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
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<tbody>
<tr>
<td>□ 1. head, face, neck and scalp</td>
<td>□ __________________________________________________________________</td>
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<tr>
<td>□ 2. ear, nose, throat</td>
<td>□ __________________________________________________________________</td>
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<td>□ 3. eyes</td>
<td>□ __________________________________________________________________</td>
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<td>□ 4. respiratory</td>
<td>□ __________________________________________________________________</td>
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<tr>
<td>□ 5. cardiovascular</td>
<td>□ __________________________________________________________________</td>
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<td>□ 6. gastrointestinal</td>
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<td>□ 7. musculoskeletal</td>
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<td>□ 8. skin</td>
<td>□ __________________________________________________________________</td>
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<td>□ 9. neurological system</td>
<td>□ __________________________________________________________________</td>
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<tr>
<td>□ 10. endocrine and metabolic system</td>
<td>□ __________________________________________________________________</td>
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</table>

Height:_________  Weight:_________  B/P:_________  Pulse:_________
Summary of defects and diagnosis (list diagnosis with item numbers).

_________________________________________________________________

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Specify any restrictions regarding student’s ability to perform in direct relation to educational expectations. This includes practical exercises in firearms training, personal defense tactics and physical training.

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Is student presently under any medical therapy?  □ yes  □ no

If yes, explain:_____________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Other remarks and/or recommendations for health maintenance:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

I have, on this day, examined ______________________________ and conclude that he/she (CHECK THE ONE APPROPRIATE BLOCK):

☐ IS physically able to participate in the physical activities of police basic training as Described in the “General Information for Physical Training Areas: Police Basic Training” form attached. I find no physical limitations that might make participation in the physical activities especially difficult for the applicant.

OR

☐ IS physically able to participate, but I find there is/are physical limitation(s) that might make participation especially difficult for the applicant. The limitation(s) is/are described above in the “CLINICAL EVALUATION” section of this report, (FORM II) and the possible problem(s) has/have been explained to the applicant. If this second block is checked, the applicant and his agency head must sign the following statements.

Dr. _________________________ has explained to me the possible problems I might have with physical training activities due to physical limitation(s) described in the “CLINICAL EVALUATION” section of this report (FORM II).

Signature of Applicant: _____________________________ Date: _______________

OFFICER _________________________ has discussed with me the possible problems he/she might have with physical training activities due to physical limitation(s) described in the “CLINICAL EVALUATION” section of this report (FORM II).

Signature of Applicant’s Agency Head: _____________________________ Date: _______________

OR

☐ Is NOT physically able to participate in the physical activities of police basic training as described in the “General Information for Physical Training Areas: Police Basic Training” form attached.

SIGNATURE OF PHYSICIAN: ______________________________ Date: ___________
The physical fitness program during police basic training is comprised of two segments:

1. Physical Fitness Assessment
2. Physical Fitness Exercise Training Curriculum

1. Fitness Assessment Activities:
   A. A sit-and-reach test to measure flexibility
   B. A one-minute sit-up test to measure dynamic strength
   C. 1.5 mile run/walk to measure cardio-respiratory endurance
   D. Threshold weight/body composition
   E. One repetition maximum bench press

2. The physical fitness curriculum is designed to develop and maintain fitness to include the following activities:
   A. Walking
   B. Running
   C. Stretching
   D. Agility Drills
   E. Strength Exercises
   F. Personal Defense Tactics

TRAINEE ENDORSEMENT:

I have thoroughly read the General Information sheet and the required medical questionnaire to the best of my ability, and understand the physical activity that is involved in police basic training. I know of no reason for not actively participating in the physical training areas, as required.

Signature of Police Academy Applicant: ____________________________________________

Date: __________________