

Student Trooper Program

Health Statement

Student Troopers Name (Print): _____

Date of Birth: _____

A qualified medical care physician must complete this section.

Please list below or on an attached page any condition(s) that the Academy Health Unit/Staff should be aware of regarding the student's medical history or current condition. Include diabetes, infections, allergies, inhalers, EpiPen, or recent illness or injury that could affect participation in moderate physical exercise.

Please list any medication(s) the above named student may be taking and the reason for taking the medication.

I certify that the above named student trooper candidate is in good physical/mental health and capable of participating in the student trooper program. I certify that his/her medical immunizations are up to date as prescribed by Massachusetts law.

PHYSICIANS NAME (PRINT)

PHYSICIAN SIGNATURE

ADDRESS

TELEPHONE

DATE

**TWO SIDED FORM – SEE REVERSE SIDE
PARENT SIGNATURE REQUIRED ON REVERSE SIDE**

Student Trooper Program

Parent/Guardian must complete this section:

I _____ parent/guardian of _____
(PRINT) (PRINT)

state that the information contained on this form is true to the best of my knowledge. I have read the section of this form completed by the physician and agree with his/her statements/certification. To the best of my knowledge the student trooper candidate is capable of moderate physical exercise.

PARENT/GUARDIAN SIGNATURE

ADDRESS

TELEPHONE

DATE