PHYSICAL EXAMINATION

PLEASE PRINT

To be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician's assistants.
A current school or sports physical may substitute, if done during the current school year. Photocopy must be included in YMRB.

YOUNG MARINE INFORMATION

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YYYY)

You are being asked to certify that this individual has no contraindication for participation in the Young Marines program.
Please fill in the following information:

VITALS

Height	Weight	Blood Pressure	Pulse

EXAMINATION

	Normal	Abnormal	Explain Abnormalities
Eyes/Vision			
Ears/Nose/Throat			
Lungs			
Heart			
Abdomen			
Hernia			
Musculoskeletal			
Neurological			
Other			

RESCTRICTIONS

Provide additional remarks or instructions if participation in the Young Marines is conditional due to any medical conditions not provided in the remarks above.

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined the person identified above and find no contraindications for participating in the Young Marines program. This participant (with noted restrictions):

	True	False	Explain
Does not have uncontrolled heart disease, asthma, seizures, or hypertension.			
Has no uncontrolled psychiatric disorders.			
Does not have poorly controlled diabetes.			

Examiner's Signature		Date of Exam	**VALID ONLY WITH PHYSICIAN'S STAMP**
Print Examiner's Name		Title	
Office Address		Suite	
City	State	Zip	
Office Telephone Number			