



# TERREBONNE PARISH SHERIFF'S OFFICE REGIONAL TRAINING ACADEMY



TIMOTHY SOIGNET  
Sheriff

CAPTAIN TIMOTHY LUCAS  
Academy Director

## BASIC TRAINING HEALTH FORM

Date: \_\_\_\_\_

*THIS FORM MUST BE COMPLETED IN ORDER TO ALLOW YOU TO ENTER THE ACADEMY. PLEASE ATTACH A FIT FOR WORK LETTER FROM DOCTOR OR A PHYSICAL WITH THE BASIC TRAINING HEALTH FORM.*

NAME: \_\_\_\_\_ DEPT. \_\_\_\_\_

COURSE \_\_\_\_\_ GENDER: M F

AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ DL: \_\_\_\_\_ SSN: \_\_\_\_\_

WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ HM PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_

EMERGENCY CONTACT: NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PH. \_\_\_\_\_

### PHYSICAL ABILITY

Do you have any physical condition(s), since your last physical, which would preclude you from participating in any of the following strenuous physical activities during the Academy?

Running:	Yes _____ No _____	Handcuffing Exercises:	Yes _____ No _____
Sit-ups:	Yes _____ No _____	Takedown/Handcuffing:	Yes _____ No _____
Push-ups:	Yes _____ No _____	Weaponless Come-alongs:	Yes _____ No _____
Firearms Training:	Yes _____ No _____	Punch/Blocking Exercises:	Yes _____ No _____
Aerobic Exercises:	Yes _____ No _____	Weapon Retention Techniques:	Yes _____ No _____
Kicking Exercises:	Yes _____ No _____	Grown-Fighting Techniques:	Yes _____ No _____
Escape Exercises:	Yes _____ No _____	Other Strenuous Activities:	Yes _____ No _____
Searching Exercises:	Yes _____ No _____	Allergies:	Yes _____ No _____

**IF THE ANSWER TO ANY OF THE ABOVE IS YES, LIST AND EXPLAIN THE PHYSICAL CONDITION(S) PRECLUDING PARTICIPATION. ANSWERING YES MAY DISQUALIFY CADET FROM ATTENDING THIS TRAINING.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## HISTORY IF ILLNESS:

Do you or have you suffered from any of the illnesses listed below?

If answered yes, Please explain.

Diabetes	Yes ___ No ___	_____
Hypertension	Yes ___ No ___	_____
Asthma	Yes ___ No ___	_____
Hepatitis	Yes ___ No ___	_____
Cancer	Yes ___ No ___	_____
Tuberculosis	Yes ___ No ___	_____
Sickle Cell	Yes ___ No ___	_____
HIV	Yes ___ No ___	_____
Epilepsy	Yes ___ No ___	_____
Heart Condition	Yes ___ No ___	_____
Arthritis	Yes ___ No ___	_____
Back problem	Yes ___ No ___	_____
Knee Problem	Yes ___ No ___	_____
Extremity Problem	Yes ___ No ___	_____
Hernia	Yes ___ No ___	_____
Hemorrhoids	Yes ___ No ___	_____
Varicose veins	Yes ___ No ___	_____
Hearing	Yes ___ No ___	_____
Anxiety	Yes ___ No ___	_____
Psychiatric Disorder	Yes ___ No ___	_____

Any other illnesses we should be made aware about:

\_\_\_\_\_

## MEDICATION

List any medication you are currently taking: \_\_\_\_\_

\_\_\_\_\_

List any allergies: \_\_\_\_\_

\_\_\_\_\_



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## SMOKING HISTORY

Use of tobacco products: Yes \_\_\_ No \_\_\_ If Yes, What? \_\_\_\_\_

## VISION

Contact lenses: Yes \_\_\_ No \_\_\_

Glasses: Yes \_\_\_ No \_\_\_

Both: Yes \_\_\_ No \_\_\_

Any other medical issue/concern that we should know about?

\_\_\_\_\_  
\_\_\_\_\_

Cadet's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Head Signature: \_\_\_\_\_ Date: \_\_\_\_\_