

Annual Health Screening Form for HPSP, NCP, FAP and NADDS Participants

Medical Questionnaire: Please remember to submit appropriate documentation along with any "YES" answers.

1. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school or training? () YES () NO

If yes, explain: _____

2. Are you now, or have you been in the care of a Health Professional during the past 12 months?

() YES () NO

If yes, explain: _____

3. Have you taken any medications in the past 12 months? () YES () NO

If yes, please list medications/over the counter preparations/supplements and reasons for their use:

4. Do you have any physical or psychological concerns which might restrict your performance on active duty or prevent your ability to come on active duty? () YES () NO

If yes, explain: _____

5. Date of your last HIV test: _____

HIV testing is required every two years. Please remember to submit proof of testing and results.

6. Current Height: _____ **Current Weight:** _____ **Age:** _____ **Sex:** _____

Personal Information:

Name: _____ **Rank:** _____ **Phone:** _____

E-Mail: _____ **Last four of Social Security Number:** _____

Grad Year: _____ **Program:** ___ HPSP ___ NCP ___ NADDS ___ FAP

I certify that the information contained in this form is true and complete to the best of my knowledge. I understand that I may be asked to provide documentation for substantiation of any "YES" answer(s).

Member Signature: _____ **Date:** _____

PRIVACY ACT STATEMENT: Authority 44 USC 3101 and EQ 9397. Principal Purpose: College information. The SSN is used to positively identify student. Routine Use: Information used to manage HPSP/FAP/NCP/NADDS program participants. Disclosure: Voluntary, however, failure to supply this information could result in suspension/termination of benefits.

Please return to the Health Readiness Section.
Email: usn.ohstudent@mail.mil Attn: Health Readiness Section