Spring Lake Beach Department - Physical Evaluation – 2020
Hand in before your swim/run test

Valid through September 30, 2010
ATTENTION! All Spring Lake Beach Department & Pool Operation

Lifeguard Candidates for the 2020 Season:
his physical form must be completed & submitted prior to testing for lifeguarding in 2020.
All guards need to complete as a minimum:
500 meter swim test under 9:45 minutes (for beach) or 10 minutes (for pool).
1 mile run under 10 minutes.
Victim carry/or sprint run

Your Physician must sign the bottom.
If there are any questions, please-mail Chief Lifeguard Janet Carbin at janet@springlakeguards.com

Part 1: APPLICANT'S MEDICAL HISTORY
Name_____ Date:_____
Address:_____ Sex:____ Age:____ Date of Birth_____
Town:_____Zip Code_____Phone #:_____

Explain "yes" answers below*: *YES NO
1. Have you been hospitalized within the past year? __ __
2. Have you had surgery within the past year? __ __
3. Are you presently taking any medication or pills for a medical condition or injury? __ __
4. Do you have any allergies (medicine, bees or other stinging insect, food)? __ __
5. Have you passed out or been dizzy during/after exercise in the past year? __ __
8. Have you had chest pain during or after exercise in the past year? __ __
Have you recently been told that you have a heart murmur by a physician or medical personnel? __ __
9. Does your heart flutter or skip heartbeats with or without exercise? __ __
10. Have you ever had a head injury? __ __
11. Have you ever had a concussion or been knocked unconscious? __ __
If so, how many have you had?____ When was the most recent?_____
12. Have you ever had any seizures that may be related to epilepsy or some other medical condition? __ __
13. Have you ever had any nerve-related injuries such as pinched nerve or burner? __ __
14. Have you experienced muscle cramps, dizziness, or passed out while exercising in the heat? __ __
15. Have you ever been diagnosed with asthma or exercised-induced asthma? __ __

If yes, what type of medication are you currently using for this condition?_____

16. Do you wear glasses, contacts, or protective eye wear? __ __

When was the last time you had your eyes examined by an optometrist?

_____

17. Please list any medical conditions not listed above that we should know about.

Applicant Signature _____ Date: _____

Physician Signature _____ Date: _____