NATIONAL SCIENCE FOUNDATION

POLAR PHYSICAL EXAMINATION

NAME:_____ DOB:_____

BLOOD TYPE: _____

COMPLETE ALL SECTIONS USING CODES WHERE APPROPRIATE

VITAL SIGNS		**VISION**			
		WITHOUT CORRECTION		WITH CORRECTION	
HEIGHT: _____	WEIGHT: _____	DIST	NEAR	DIST	NEAR
BP: ____/____	HEART RATE: _____	R _____	_____	R _____	_____
RESPIRATIONS: ____	TEMPERATURE: _____	L _____	_____	L _____	_____

CODES: O – Within Limits
I – Significantly Abnormal
X – Not Examined

		Code	Remarks (discuss abnormal findings in detail)
1.	General Appearance….....		
2.	Head and neck….....		
3.	Eyes….....		
4.	Ears….....		
5.	Nose….....		
6.	Mouth….....		
7.	Thyroid….....		
8.	Lymph nodes….....		
9.	Chest, Lungs, Breasts….....		
10.	Heart….....		
11.	Abdomen….....		
12.	Inguinal, include hernia….....		
13.	Genitalia….....		
14.	Anal and Rectum….....		
15.	Spine….....		
	Forward Bend, Fingers Miss Floor ___ Inches		
16.	Upper Extremities….....		
17.	Lower Extremities….....		
	Varicosities….....		
18.	Skin, Lymphadenopathy….....		
	Identify Body Marks, Scars, Tattoos….....		
19.	Peripheral Vascular….....		
20.	Neurologic Status (include Reflexes)….		
21.	Emotional Status….....		
22.	Pelvic Exam….....		
23.	Men > Age 40: Prostate Exam….....		

NAME_____ DOB _____

Physical Examination

Guiac Test (Required annually for age 50 and up)	Tetanus Immunization Date (Update every 10 years)	TB Skin Test (Required Annually)
_____ _____ Results Date	_____ Date	_____ _____ Results Date

Examiner's Diagnoses and Comments:

(Please ask the candidate if there is any other medical information not already obtained which should be known prior to deployment.)

I have thoroughly examined this candidate for travel to the Polar Regions. I have reviewed the participant's history with him/her, including ALL positive responses, and commented appropriately. I have performed all diagnostic tests as requested.

_____ _____

Examiner's Name (Type or Print): Examiner's Signature DATE

_____

ADDRESS

_____

CITY STATE ZIP

I have been informed regarding the medical examination findings herein (signature optional).

PHONE #:_____

_____

PATIENT'S SIGNATURE DATE

Return the completed examination form and results of the requested tests to (return envelope enclosed):

National Science Foundation
Attention: **NSF Medical Director**
4201 Wilson Boulevard, Ste 265-S
Arlington, VA 22230
703-292-8124 Fax: 703-292-9001