

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](mailto: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: \_\_\_\_\_