NM TASERS AND MORE TRAINING LLC

COMPREHENSIVE MEDICAL CLEARANCE & PHYSICIAN AUTHORIZATION FOR TASER EXPOSURE TRAINING

SECTION 1 — PARTICIPANT INFORMATION

Full Name: _____
DOB: _____
Phone: _____
Address: _____

SECTION 2 — PURPOSE OF FORM

The above-named individual is seeking **medical clearance to participate in voluntary TASER (Conducted Electrical Weapon / CEW) Exposure Training**. This training may involve exposure to a neuromuscular incapacitation (NMI) cycle lasting approximately five (5) seconds. The purpose of this form is to evaluate whether the participant has any **medical condition, history, or risk factor** that would reasonably increase the likelihood of injury or adverse reaction to TASER exposure.

SECTION 3 — DETAILED RISKS OF TASER EXPOSURE

The following risks must be understood by both the participant and the medical provider.

A. CARDIOVASCULAR RISKS

TASER/CEW exposure may increase cardiac workload. Risks may include:

- Elevated heart rate, blood pressure, and stress on the cardiovascular system
- Potential for arrhythmias, especially in predisposed individuals
- Increased risk for persons with:

Doctor Initials: _____ Student Initials: _____

- Coronary artery disease
- Prior myocardial infarction
- CHF (Congestive Heart Failure)
- Cardiomyopathy
- Structural heart abnormalities
- Implanted devices (pacemaker, ICD)

Note: Although rare, cardiac capture or induction of arrhythmia with chest-proximal exposure has been reported.

B. NEUROLOGICAL & SEIZURE-RELATED RISKS

TASER exposure may cause intense involuntary contractions and brief neurological disruption.

Risks include:

- Triggering a seizure in individuals with seizure disorders
- Post-ictal confusion
- Aggravation of neurological conditions
- Temporary tingling, numbness, or peripheral nerve irritation
- Increased risk if the participant has a history of:
  - Epilepsy
  - Brain injury
  - Stroke
  - Neuralgia
  - Migraine disorders

C. MUSCULOSKELETAL & IMPACT RISKS

During NMI, the participant may fall or lose control of posture.

Risks include:

- Sprains, strains, muscle tears
- Dislocations (particularly shoulders)
- Fractures from falls
- Spinal injuries, especially for individuals with:
    - Osteoporosis
    - Degenerative disc disease
    - Scoliosis
    - Recent surgery
    - Chronic back or neck pain

D. RESPIRATORY RISKS

Exposure may cause:

- Brief difficulty breathing or inability to inhale fully
- Aggravation of asthma or COPD
- Spasms affecting chest wall musculature
- Hyperventilation or panic reactions

Individuals with respiratory disease may be at higher risk.

E. METABOLIC & OTHER RISKS

CEW exposure may aggravate:

- Diabetes (glucose fluctuations)
- Thyroid disease
- Adrenal conditions
- Heat intolerance
- Dehydration-related complications

Doctor Initials: _____ Student Initials: _____

F. PREGNANCY RISKS

Exposure **is not recommended** for pregnant individuals, due to risks including:

- Stress response
- Abdominal wall contractions
- Fall-related trauma
- Placental complications

G. PSYCHIATRIC AND BEHAVIORAL RISKS

Certain conditions may increase risk of:

- Panic
- Hyperventilation
- Exaggerated stress response

Risks are heightened in individuals with:

- PTSD
- Anxiety or panic disorders
- Severe depression
- Current intoxication
- Psychosis

H. IMPLANTED MEDICAL DEVICES

Participants with the following **may NOT be cleared** unless a physician determines otherwise:

- Pacemaker
- Internal cardioverter defibrillator (ICD)
- Vagal nerve stimulators
- Spinal cord stimulators

Doctor Initials: _____ Student Initials: _____

- Deep brain stimulators
- Insulin pumps
- Any electronic or semi-electronic medical implant

SECTION 4 — DETAILED MEDICAL HISTORY REVIEW

(Provider must complete all sections)

Cardiovascular History

☐ No known issues
☐ Hypertension
☐ Arrhythmia
☐ Coronary artery disease
☐ Prior MI / Heart attack
☐ CHF
☐ Pacemaker / ICD
☐ Other: _____

Neurological History

☐ No known issues
☐ Seizure disorder
☐ TBI
☐ Stroke
☐ Neuropathy
☐ Other: _____

Respiratory History

☐ No known issues
☐ Asthma
Severity: ☐ Mild ☐ Moderate ☐ Severe
☐ COPD
☐ Other: _____

Musculoskeletal History

☐ No known issues
☐ Chronic back/neck pain
☐ Degenerative disc disease

Doctor Initials: _____ Student Initials: _____

☐ Osteoporosis
☐ Hypermobile joints
☐ Recent surgery
☐ Other: _____

Metabolic / Endocrine History

☐ No known issues
☐ Diabetes
☐ Thyroid disease
☐ Adrenal disorders
☐ Electrolyte disorders
☐ Other: _____

Implanted Devices

☐ None
☐ Pacemaker
☐ Defibrillator
☐ Insulin pump
☐ Neurological implant
☐ Other: _____

Psychological History

☐ No known issues
☐ PTSD
☐ Anxiety
☐ Panic disorder
☐ Depression
☐ Other: _____

Medications (List all):

_____

_____

Allergies:

_____

Pregnancy Status (if applicable):

Doctor Initials: _____ Student Initials: _____

☐ Patient affirms NOT pregnant
☐ Pregnancy possible / unknown
☐ Declined to state

SECTION 5 — PHYSICAL EXAMINATION (OPTIONAL BUT RECOMMENDED)

(Provider may complete as applicable)

Vital Signs

BP: _____
Pulse: _____
Respirations: _____
O2 Sat: _____%
Temperature: _____

Cardiac exam: ☐ Normal ☐ Abnormal (explain)

Respiratory exam: ☐ Normal ☐ Abnormal (explain)

Neurological exam: ☐ Normal ☐ Abnormal (explain)

General physical condition:

☐ Fit for physical stressors
☐ Concerns noted: _____

SECTION 6 — PHYSICIAN CLEARANCE

After reviewing the participant's medical history, performing an examination when indicated, and considering the risks associated with TASER exposure:

Provider Determination:

☐ **CLEARED WITHOUT RESTRICTIONS**
I find no medical condition that would reasonably place the participant at increased risk during CEW exposure.

Doctor Initials: _____ Student Initials: _____

☐ **CLEARED WITH RESTRICTIONS**
Describe restrictions:

☐ **NOT CLEARED FOR TASER EXPOSURE**
Due to the following medical concerns:

SECTION 7 — PROVIDER INFORMATION & CERTIFICATION

Provider Name (Print): _____
Credentials (MD/DO/PA/NP/etc.): _____
Clinic/Facility: _____
Phone: _____
Address: _____

Provider Signature: _____ **Date:** _____

SECTION 8 — PARTICIPANT ACKNOWLEDGMENT

I acknowledge the risks associated with TASER/CEW exposure and agree that I have provided truthful and complete information to my medical provider.

Participant Signature: _____ **Date:** _____