

Athletic Training Student Health Assessment

TO BE COMPLETED BY PHYSICIAN ONLY:

NAME: _____ DATE: _____

DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ BP _____ / _____ PULSE: _____

PEAK FLOW (IF APPLICABLE): _____ PREDICTED: _____

	NORMAL	ABNORMAL (PLEASE EXPLAIN)	INITIALS
MEDICAL			
Appearance			
Lungs			
CV			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder			
Elbow			
Wrist			
Hip			
Knee			
Foot/Ankle			
Any clinical evidence of communicable disease? YES NO			

Based on your examination, should this patient's physical and mental health permit them to meet the technical standards of the Athletic Training Education Program? ___ Yes ___ NO

Approval for participation without limitation? ___ Yes ___ No If "no", please explain below

Recommendations: _____

Name of Physician (print/type) _____ Phone: _____

Signature of Physician: _____ Date: _____

Athletic Training Student
Health Assessment Questionnaire

Name: _____

Date: _____

Date of Birth: _____

1. Are you currently under the care of a physician for any reason? Yes No

If yes, please describe: _____

2. Do you take any prescription medications? Yes No

If yes, please list: _____

3. Do you take any over-the-counter medications or herbs/supplements? Yes No

4. Have you ever been told that you have HIV, Hepatitis B, Hepatitis C, or tuberculosis?

Yes No

5. Have you been immunized against Hepatitis B? Yes No

If yes, did you complete the series of 3 injections? Yes No

6. Have you ever had a positive skin test for tuberculosis? Yes No

7. Have you been out of the US in the past 3 years? Yes No

If yes, where? _____

8. To your knowledge, have you been exposed to anyone with tuberculosis? Yes No

9. Do you have any history of heat cramps, heat exhaustion, or heat stroke? Yes No

If yes, please describe: _____

10. Do you have any medical or physical condition that would interfere with your ability to fulfill the responsibilities of an athletic training student? Yes No

Please explain all "yes" answers below:
