Emporia State University
Teachers College
Master of Science in Athletic Training Program

HEALTH FORM / PHYSICAN'S EXAMINATION

PART ONE: MUST BE COMPLETED BY THE STUDENT PRIOR TO THE EXAM!

Immunization data and tests results (dates, type of test, etc.,) should be obtained from the physician or clinic administering the immunizations or tests. If the physician doing the examination has all of the necessary records, the student is not responsible for supplying the immunization data.

General Information:

Name:_____ Sex:_____ Age:_____

Address:_____ Phone:_____

City:_____ State: _____ Zip:_____

History:
Do you have, or have you had any of the following illnesses or conditions?

Asthma	Yes	☐	No	☐	Diabetes	Yes	☐	No	☐
High Blood Pressure	Yes	☐	No	☐	Heart Disease	Yes	☐	No	☐
Cancer	Yes	☐	No	☐	TB	Yes	☐	No	☐
Seizures	Yes	☐	No	☐	Hepatitis	Yes	☐	No	☐
Other serious illness or condition currently	Yes	☐	No	☐					

Details of any "Yes" answers from above:

_____

_____

Previous Injuries: _____

Previous Surgeries: _____

Allergies: _____

Current Medications: _____

REQUIRED:	Date Completed/Given	Result	Recorder
Primary DPT series completion **Tetanus Booster** (within last 10 years)	_____ _____		
MMR **Born before 1/1/57** or **Vaccine- Dose # 1** **Dose # 2**	_____ _____ _____		
Hepatitis B Vaccine First Injection Second Injection: (1 month after first injection) Third Injection: (5 months after second injection) Surface Antibody Test: (6-8 weeks after last injection)	_____ _____ _____ _____	_____	_____ _____ _____ _____
PPD (tuberculin skin test) Step 1: Step 2: (7-14 days after step 1) Step 3: (1 year follow-up) **If PPD (+), CXR** (within last year)	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Varicella Varicella titer or Vaccine- Dose # 1 Dose # 2	_____ _____ _____	_____	_____ _____ _____

PART TWO: TO BE COMPLETED BY THE PHYSICIAN (MD/DO/NP/PA)

Physical Examination:

Vital Signs: Ht: _____ (inches) Wt: _____ (lbs.) BP_____/_____ Pulse _____

	Normal	Abnormal	Deferred	Comments
General Appearance				
HEENT				
Lungs				
Breast (if indicated)				
Heart				
Abdomen				
Pelvic (if indicated)				
Rectal (if indicated)				
Back				
Extremities				
Neurologic				

Are there any conditions, physical and/or emotional, which may interfere with functioning as a health professional student in the classroom or clinic?

☐ Yes ☐ No If yes, please describe on a separate sheet.

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

Consent:

I understand that a copy of this exam form, including laboratory results may be sent to my assigned clinical centers and coordinators.

Student Signature: _____ Date: _____

Practitioner Contact:

If you are currently in treatment for any condition, physical or emotional, may we contact your practitioner in an emergency? Yes ☐ No ☐

Student Signature: _____ Date: _____

If yes, please provide us with the following information:

Practitioner's Name: _____ Specialty: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____