

**Emporia State University  
Teachers College  
Athletic Training Program**

**HEALTH FORM / PHYSICIAN'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	<input type="checkbox"/>	No	<input type="checkbox"/>	Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
High Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Heart Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	TB	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Seizures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Hepatitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other serious illness or condition <u>currently</u>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>					

Details of any "Yes" answers from above:

---

---

Previous Injuries: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

---

REQUIRED:	Date Completed/Given	Result	Recorder
<b>Primary DPT series completion</b> <b>Tetanus Booster</b> (within last 10 years)	_____ _____		
<b>MMR</b> <b>Born before 1/1/57</b> or <b>Vaccine- Dose # 1</b>  <b>Dose # 2</b>	_____ _____ _____		
<b>Hepatitis B Vaccine</b> 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)	_____ _____ _____ _____	_____ _____ _____	_____ _____ _____ _____
<b>PPD (tuberculin skin test)</b> Step 1:  Step 2: (7-14 days after step 1)  Step 3: (1 year follow-up)  <b>If PPD (+), CXR (within last year)</b>	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
<b>Varicella</b> 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: \_\_\_\_\_