

**Western Carolina University  
Athletic Training Education Program**

**Name:** \_\_\_\_\_ **ID#** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Last First Middle Initial

**Address (home):** \_\_\_\_\_  
Street City State Zip Phone

**Health History:** Please answer each of the following by circling YES or NO.

**1. Have you, or anyone in your immediate family ever had:**

- |  |     |    |                      |     |    |
|--|-----|----|----------------------|-----|----|
| A. Diabetes (High Blood Sugar)         | YES | NO | B. Asthma            | YES | NO |
| C. Migraines                           | YES | NO | D. Heart Trouble     | YES | NO |
| E. High Blood Pressure                 | YES | NO | F. Enlarged Heart    | YES | NO |
| G. Hypertrophic Cardiomyopathy         | YES | NO | H. Heart Murmur      | YES | NO |
| I. Abnormal Heart Rhythm               | YES | NO | J. Marfan's Syndrome | YES | NO |
| K. Dizziness with exercise or exertion | YES | NO |                      |     |    |

**2. Do you have, or have you ever had:**

- |                             |     |    |                          |     |    |
|-----------------------------|-----|----|--------------------------|-----|----|
| A. Concussion/Head Injury   | YES | NO | B. Loss of Consciousness | YES | NO |
| C. Convulsions or Epilepsy  | YES | NO | D. Hearing Loss          | YES | NO |
| E. Impaired Vision          | YES | NO | F. Glasses or Contacts   | YES | NO |
| G. Allergies                | YES | NO | H. Mononucleosis         | YES | NO |
| I. Anemia                   | YES | NO | J. Tuberculosis          | YES | NO |
| K. Loss of one paired organ | YES | NO | L. Surgery               | YES | NO |

**3. Do you have, or have you ever had:**

- |                                |     |    |                      |     |    |
|--------------------------------|-----|----|----------------------|-----|----|
| A. Bone Fracture/Break         | YES | NO | B. Joint Dislocation | YES | NO |
| C. Neck Injury                 | YES | NO | D. Shoulder Injury   | YES | NO |
| E. Elbow, Wrist or Hand Injury | YES | NO | F. Back Injury       | YES | NO |
| G. Hip Injury                  | YES | NO | H. Knee Injury       | YES | NO |
| I. Ankle Injury                | YES | NO |                      |     |    |

**4. Do you take any Medications Regularly?** YES NO

**5. Do you have any physical limitations, that may affect your abilities as an athletic trainer?** YES NO

Please Explain all "Yes" Answers above, please be specific giving dates. \_\_\_\_\_

**Immunization Record:**

**Measles, Mumps & Rubella Vaccine (MMR):**

\_\_\_\_\_ 2 doses, 1<sup>st</sup> at age 15 months or later, 2<sup>nd</sup> in 1980 or later. Dose 1: \_\_\_\_\_ Dose 2: \_\_\_\_\_

**Tuberculosis: Check appropriate Line (Note- Tine or Monovac not acceptable)**

\_\_\_\_\_ PPD (Mantoux) test since June 1 of the application year: Date Read: \_\_\_\_\_ Result: \_\_\_\_\_

\_\_\_\_\_ Positive PPD-Chest X-Ray required. Date: \_\_\_\_\_ Result: \_\_\_\_\_

**Tetanus-Diphtheria:**

\_\_\_\_\_ Completed primary series of tetanus-diphtheria immunizations. Date: \_\_\_\_\_

\_\_\_\_\_ Received Td Booster within the last 10 years: Date: \_\_\_\_\_

**Polio Series:**

Date primary series completed: \_\_\_\_\_ Date of last dose: \_\_\_\_\_

**Varicella Immunity:** (one of the following must apply)

**Documented** history of chicken pox (must be in medical record!) Date: \_\_\_\_\_

Positive Antibody Screening: Reading: \_\_\_\_\_ Date: \_\_\_\_\_

Varicella Vaccination: Date: \_\_\_\_\_

**Hepatitis B Vaccine:** (Recommended- if not opted, a waiver must be signed)

Dose 1: \_\_\_\_\_ Dose 2: \_\_\_\_\_ Dose 3: \_\_\_\_\_

Positive Antibody Screening (recommended): Reading: \_\_\_\_\_ Date: \_\_\_\_\_

**Meningitis Vaccine:** (Recommended)

\_\_\_\_\_ Completed Date: \_\_\_\_\_

**Reviewed and Approved by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Physician/ Physician Assistant/ Nurse Practitioner)

**Name:** \_\_\_\_\_ **ID#** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Last First Middle Initial

**Physical Exam:** BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

If there are any **ABNORMALITIES** of any of the following, please describe.

<b>Skin, Hair, Nails</b>	<b>Head/Nose/Sinuses</b>
<b>Eyes</b>  <b>Vision: WNL?</b> <b>Yes</b> ___ <b>No</b> ___ <b>Corrective Lenses?</b> <b>Yes</b> ___ <b>No</b> ___	<b>Ears</b>  <b>Hearing: WNL?</b> <b>Yes</b> ___ <b>No</b> ___ <b>Correction Required?</b> <b>Yes</b> ___ <b>No</b> ___
<b>Heart and Blood Vessels</b>	<b>Chest and Lungs</b>
<b>Abdomen</b>	<b>Neck</b>
<b>Throat and Mouth</b>	<b>Neurological</b>
<b>Musculoskeletal</b>	<b>General Assessment Summary</b>

The Athletic Training Education Program at Western Carolina University is a rigorous and intense program that places specific requirements and demands on the students enrolled in the program. Students enrolled in the Athletic Training Education Program must demonstrate the following:

1. The mental capacity to assimilate, analyze, synthesize, integrate concepts and problem solve to formulate assessment and therapeutic judgments and be able to distinguish deviations from the norm.
2. Sufficient postural and neuromuscular control, sensory function, and coordination to perform appropriate physical examinations using accepted techniques; and accurately, safely and efficiently use equipment and materials during the assessment and treatment of patients.
3. The ability to physically move equipment, assist in athlete/patient mobility and transfers, perform emergency procedures (ie: cardiopulmonary resuscitation) and complete other physical tasks associated with the profession of athletic training. The ability to lift 25 pounds is a general guideline.
4. The ability to communicate effectively and sensitively with patients and colleagues, including individuals from different cultural and social backgrounds; this includes, but is not limited to, the ability to establish rapport with patients and communicate judgments and treatment information effectively. Students must be able to understand and speak the English language at a level consistent with competent professional practice.
5. The ability to record the physical examination results and a treatment plan clearly and accurately.
6. The capacity to maintain composure and continue to function well during periods of high stress, including demonstrating appropriate coping mechanisms that allow for adequate emotional and mental stability to provide care for others
7. Flexibility and the ability to adjust to changing situations and uncertainty in clinical situations.
8. Affective skills and appropriate demeanor and rapport that relate to professional education and quality patient care.

I feel that, based upon my physical examination, this student is medically capable of performing the above tasks and completing the clinical experiences required by the Western Carolina University Athletic Training Education Program.

Physician /Physician Assistant/Nurse Practitioner Signature: \_\_\_\_\_

Physician or Practitioner: (PLEASE PRINT NAME): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Examination: \_\_\_\_\_