MURRAY STATE UNIVERSITY Athletic Training – Sports Medicine ATHLETIC TRAINING EDUCATION PROGRAM PHYSICAL EXAM

LAST NAME:	FIRST NAME:			MIDDLE NAME:			
DATE OF BIRTH:	F BIRTH: SS#:			GENDER:			
Height: inches /	ftin	Weight:	lbs	Pulse:	Blood Pressure:		
Urinalysis: pH:	Specific Gravity:		POS NEG				POS NEG TRACE
Vision Screening: Right 20/ Left 20/ Both 20/ Both 20/ Were contacts/glasses worn? Yes No Corrected: Right 20/ Left 20/ Both 20/							
Orthopedic Exam:							
HEAD/NECK:							
SHOULDERS: Right:Left:							
ELBOWS/HANDS/WRIS	TS:						
LOW BACK:							
PELVIS/HIPS:							
KNEES: Right:			Left: _				
ANKLES: Right:			Left: _				
LOWER LEGS/FEET/TO	DES:						
Physician Exam:							
HEART/LUNGS:							
GENITALIA/HERNIA (M							
I believe the aforementioned Applicant for the Athletic Training Education Program has met / has not met the requirements set forth in the Technical Standards and will / will not be able to perform the Essential Skills (with or without accommodation) necessary to succeed in the Athletic Training Education Program and be a successful entry-level certified athletic trainer. (See reverse for Technical Standards and Essential Skills.)							
Disposition: Cleared Hold Reason:							

Physician Signature: ______ Date: _____