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.___________________________________

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Immunization Record:

Measles, Mumps & Rubella Vaccine (MMR):

_____2 doses, 1st at age 15 months or later, 2nd 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.

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

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:___________________________