

Medical Clearance Form

INSTRUCTIONS: Students applying to the Athletic Training Major should fill out the first page of this form. The form can then be brought to your health care professional (MD, DO, NP or PA) for completion of the required medical clearance.

NAME: _____	WARRIOR ID # _____	
GENDER: Male Female	DATE OF BIRTH: _____	AGE: _____
ADDRESS: _____	PHONE: _____	
PERSONAL PHYSICIAN: _____	PHONE: _____	
<i>In Case of Emergency Contact:</i>		
Name: _____	Relationship: _____	Phone: _____

EMERGENCY INFORMATION:

Allergies: _____

Other Important Information: _____

IMMUNIZATIONS: Report the dates completed for the following immunizations.

Diphtheria/Tetanus (Td) _____ Measles _____

Mumps _____ Rubella _____

Hepatitis B _____ or Hepatitis B Waiver _____

ATHLETIC TRAINING STUDENT STATEMENT OF CONTINUED HEALTH RESPONSIBILITY

If there is a change in my health status, I understand a subsequent health examination may be required by the College of Nursing and Health Sciences Administration. I understand it is my responsibility throughout the program to inform the Director/Clinical Coordinator of the ATEP and my preceptors of any conditions that may affect my performance or the welfare of my patients in the clinical area. I understand this is necessary so arrangements can be made in my courses and clinical experiences. I understand that this disclosure is necessary to protect my health and well being as well as the health and well being of those I may provide care for.

Signature: _____

Date: _____

Physical Evaluation Clearance Form

Patient Name: _____ DOB: _____ Date: _____

PHYSICIAN INSTRUCTIONS:

As a health care provider, you are being asked to determine whether this individual may have difficulty completing the requirements for their Athletic Training clinical education. Students must possess certain abilities in order to provide safe practice. These abilities include:

- A. Functional use of all sense
- B. Ability to perceive pain, pressure, temperature, position, equilibrium and movement
- C. Functional use of gross and fine motor skills to carry out assessment and care delivery, such as lifting, transferring and treatments.
- D. Ability to interact in a behaviorally appropriate manner.

Please review with the prospective student any health problems or conditions that may influence their ability to perform the above tasks in the following areas: (Please note – The WSU ATEP is NOT asking for these specific conditions to be reported on this document, only that they are addressed privately with the student during the examination.)

- A. Metabolic, i.e., diabetes
- B. Neurologic, i.e., epilepsy
- C. Cardiovascular;
- D. Musculoskeletal, i.e., arthritis or low back pain;
- E. Infections/Communicable disease;
- F. Mental/Emotional stress which may affect student performance, jeopardizing the health and well being of the student or person being cared for by the student.

Please complete any necessary history and physical exam data collection to determine the student's ability to function clinically based upon the above criteria. **Please note that a Mantoux test is also required for this physical exam. A verification section for this test can be found below.**

Please indicate the results of your data collection:

1. _____ IS/IS NOT (circle one) physically and/or emotionally able to meet the functional abilities to practice in the clinical setting.
2. The following restrictions and/or limitations would affect the student's ability to meet each of these standards:

Mantoux Test (required)

Result: _____ Date: _____

Physician's Signature: _____ Date: _____

Name of Physician (Print): _____

Address: _____

Phone: _____ Fax: _____