Wichita State University
Master of Science in Athletic Training
1845 Fairmount
Wichita, KS 67260-0016

REPORT OF MEDICAL HISTORY

Last Name: ______________________   First Name: _______________   MI: _________

SS#:   Gender (cslr): F7b

B) Personal History: *Please provide information about past personal medical conditions.*

Medical Condition:			**Date:**
Asthma	YES	NO	________________
Allergies	YES	NO	________________
Cancer	YES	NO	________________
Depression	YES	NO	________________
Diabetes	YES	NO	________________
Headaches/Migraines	YES	NO	________________
Heart Conditions	YES	NO	________________
High Blood Pressure	YES	NO	________________
High Cholesterol	YES	NO	________________
Liver Disease	YES	NO	________________
Seizures	YES	NO	________________
Thyroid Problems	YES	NO	________________
ms	YES	NO	________________
Vision/Eye Problems	YES	NO	________________
Other Conditions	YES	NO	________________

If yes, please specify: ____

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C) Immunization Record: *Please provide information about your health immunization. A copy nization record from your pediatrician or family physician may be necessary to accurately transfer dates to this record.*

Vaccine	**Record of Data**					
	1st	**2nd**	**3rd**	**4th**	**5th**	**6th**
Diphtheria, Pertussis, & Tetanus, (DPT)	/	/	/	/	/	/
Tetanus or Tetanus-Diphtheria (Td)	/	/	/	/	/	/
Polio	/	/	/	/	/	/
	/	/	/	/	/	/
Varicella (Chicken Pox)	/	/	/	/	/	/
Tuberculin (TB)	/	/	/	/	/	/
Hepatitis B	/	/	/	/	/	/
Covid-19	/	/	/	/	/	/
	/	/	/	/	/	/

D) <u>Communicable Disease Screening</u>:

The Wichita State University Master of Science in Athletic Training (MSAT) has adopted the following policies and procedures for athletic training students to complete if symptoms of a communicable disease are present or suspected. Students may not participate in clinical

2. Are you taking any medications daily? YES NO

If yes, please specify: ____

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3. Have you ever been hospitalized for any surgeries or major illnesses? YES NO

If yes, please specify: ____

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I certify to the best of my knowledge that the information on this form is true and accurate.

____

Signature of Student (Parent or legal guardian if less than 18 years of age) Date

Verification Form

I certify this individual is of sound health to perform the physical and mental abilities in the Master of Science in Athletic Training. In addition, I have reviewed his/her family history, personal history, immunization record, and communicable disease history. At this time, the student is clear of physical injury and disease.

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Signature of Physician | Date

( )
____

Name of Physician (Please print) | Phone

____

Address | City/State | Zip

Emergency Contact Information