Wheeling Jesuit University

Athletic Training Education Program Physical Form

All Forms Must Be Completed and Returned before your clinical rotation site begins in the fall.

PLEASE PRINT CLEARLY

Name: (Last) ____________________________ (First) __________________ (Middle) ___________ Sex: M __ F __

Date of Birth: (mo) _______ (day) _______ (yr) _______ Email you check regularly: ____________________________________

(Street Address) ____ (City) ________________________

(State or Country) __________________________ (Zip) ______________ Home Telephone: [_____] _____________________

Please check: commuter _____ campus resident _____ Student Cell: [_____] _____________________

Year Entering _______ Please check: Entering Fall Semester ______ Entering Spring Semester ______

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PLEASE PRINT CLEARLY

Emergency Contact Person: ____ Relationship: ___________________________

(Street) ________________________________ (City) _______________________ (State/Country) ________________ (Zip) __________

Home Telephone: [_____] ____________________ Alternative Telephone Number: [_____] _____________________________________

Emergency contact email: ____

Name of Family Physician/Health Care Provider: ____ Telephone: [_____] _________________

(Street) _________________________________ (City) _____________________________ (State/Country) ___________ (Zip) __________

ALL ATEP STUDENTS MUST PROVIDE PROOF OF HAVING MEDICAL INSURANCE COVERAGE.

This requirement is to ensure that all students will have access to medical care if needed. Your medical insurance information will be kept confidential and on file for scheduling medical referrals to outside physicians, outpatient treatment, emergencies, and/or participation in University athletics.

Insurance company/provider: ______________________________ Policy No. ___________________Group No. (if applicable) ____________________

YOU MUST ALSO PROVIDE A FRONT/BACK COPY OF YOUR INSURANCE CARD WITH THIS FORM.

STUDENT SIGNATURE REQUIRED IF AGE 18 OR OVER.

I hereby authorize the WJU Student Wellness Center to render services deemed necessary for my health and well-being. I grant permission for my transfer to an accredited hospital or other care facility if deemed necessary by the Dean of Student Development or his/her designee. I agree to be responsible for any expense in connection with the aforesaid, if my insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my treatment by their facility to the Wheeling Jesuit University Student Wellness Center for continuity of care.

Signature: ____ Date: ____________________________

PARENT/GUARDIAN SIGNATURE REQUIRED IF STUDENT IS UNDER THE AGE OF 18.

I hereby authorize the WJU Student Wellness Center to render services deemed necessary for my student's health and well-being. I grant permission for my student's transfer to an accredited hospital or other care facility if deemed necessary by the Dean of Student Development or his/her designee. I agree to be responsible for any expense in connection with the aforesaid, if my student's insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my student's treatment by their facility to the Wheeling Jesuit University Student Wellness Center for continuity of care.

Signature of parent/guardian: ____ Date: ____________________________

PERSONAL HEALTH HISTORY TO BE FILLED OUT BY ATEP STUDENT

This information will be used only as an aid in the consideration of your health needs and will remain confidential among the appropriate healthcare professionals. PLEASE USE ADDITIONAL SHEETS OF PAPER IF NECESSARY.

Are you presently under any medical treatment? Yes o No o
If *yes*, explain: ____
Are you taking any medications at present (prescription, nonprescription, inhaler)? Yes o No o
If *yes*, explain: ____
Are you now receiving or have you ever received professional help for emotional or psychological problems? Yes o No o
If *yes*, when: ____
Do you have a physical impairment such as paralysis, loss of vision, hearing, etc.? Yes o No o
If *yes*, explain: ____
Do you have any sensitivity to food, medicine, or environmental contact? Yes o No o
If *yes*, explain: ____
Have you ever had a head injury or concussion? Yes o No o
If *yes*, explain and give dates: ____
Has a physician ever denied or restricted your participation in sports for any health problems? Yes o No o
If *yes*, explain: ____

Have you ever had, or do you currently have:
o Chicken Pox
o Nervous Tendencies
o Rheumatic Fever
o Heat Related Illness
o Heart Disease
o Mononucleosis
o Tuberculosis
o Asthma, Hay Fever, or Hives
o Hepatitis
o Diabetes
o Convulsions or "black outs"
o Eating Disorders
o Seizures
o Heart Murmur
o Pregnancies - Date of last menstrual period: ____________________
o Loss of function of a "paired organ" (eye, ear, testicle, ovary, kidney)
o NONE OF THE ABOVE

If you checked any of the above, please provide further information: ____

____

Dates of significant injuries or operations or medical admissions to hospitals: o NONE ____

____

Personal Habits (please indicate use of any of the following):
o Smoking tobacco o Smokeless Tobacco o Alcohol o Dietary Supplements o Dental appliances o NONE

ALLERGIES/REACTIONS:
Latex: ______________________________ Food: ______________________________

Dyes: ______________________________ Medication: ______________________________

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I also state that a licensed Physician or Nurse Practitioner completed my Physical Form.

Student Signature: ______________________________ Date: ______________________

Signature of parent/guardian: ______________________________ Date: ______________________

(If under the age of 18)

A PHYSICIAN MUST <u>COMPLETE</u>, <u>SIGN</u>, AND <u>DATE</u> THIS FORM.

PLEASE PRINT
STUDENT NAME: ____________________________ ________________________________ __________
Last First Middle Initial

Family history:
Among your immediate relatives (parents, siblings and grandparents), is there any history of, or present illness from, any of the following:

- o Cancer
- o Diabetes
- o Asthma, Hay Fever, or other Allergies
- o Heart Disease
- o Marfan's Disease
- o Sudden death under age 50 from non-trauma cause

Please explain any of the marked replies: ____

Height: __________________ Weight: __________________ Blood Pressure: ____________________ Pulse: __________________

LIST MEDICATIONS: ____

General Exam

Normal	Abnormal	Notes of Abnormality
________Skin	________	
________Hearing	________	
________Head	________	
________Ear, Nose, & Throat	________	
________Neck: Thyroid	________	
________Cardiovascular	________	
________Lungs	________	
________Breasts	________	
________Abdomen	________	
________Genitalia	________	
________Menstruation	________	
________Back & Extremities	________	
________Reflexes	________	

Orthopedic Exam

Normal	Abnormal	Notes of Abnormality
_______Cervical Spine	________	
_______Thoracic Spine	________	
_______Lumbar Spine	________	
_______Shoulders	________	
_______Elbows	________	
_______Wrists, Hands, Fingers	________	
_______Hips/Pelvis	________	
_______Knee	________	
_______Ankles, Feet, Toes	________	
_______General Flexibility	________	

Comments:____
____
____
____
____
____

Check only <u>ONE</u> of the boxes below:

☐I certify that I have examined the student and have found ***<u>no obvious condition(s)</u>*** that would prevent him/her from meeting the criteria listed in the physical portion of the Technical Standards for Admission to the ATEP program at Wheeling Jesuit University. (Standards 1-4).

☐ I certify that I have examined the student and have found ***<u>an obvious condition(s)</u>*** that would prevent him/her from meeting the criteria listed in the physical portion of the Technical Standards for Admission to the ATEP program at Wheeling Jesuit University. (Standards 1-4). I recommend that the student contact notify the Program Director and work with the University's Academic Resource Center to discuss accommodation options.

Physician Signature: ____ Date: __________________