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): F M

B) <u>Personal History</u>: *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	
[redacted]ms	YES	NO	
Vision/Eye Problems	YES	NO	
Other Conditions	YES	NO	

If yes, please specify: _____

C) <u>Immunization Record</u>: *Please provide information about your health immunization. A copy of [redacted]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	/	/	/	/	/	/
[redacted]	/	/	/	/	/	/
Varicella (Chicken Pox)	/	/	/	/	/	/
Tuberculin (TB)	/	/	/	/	/	/
Hepatitis B	/	/	/	/	/	/
Covid-19	/	/	/	/	/	/
[redacted]	/	/	/	/	/	/

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: _____

_____

_____

3. Have you ever been hospitalized for any surgeries or major illnesses? YES NO
If yes, please specify: _____

_____

_____

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.

Signature of Physician	Date
Name of Physician (Please print)	( ) Phone
Address City/State	Zip

<u>Emergency Contact Information</u>