

*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~~Ø~~

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	_____
_____ns	YES	NO	_____
Vision/Eye Problems	YES	NO	_____
Other Conditions	YES	NO	_____

If yes, please specify: _____

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

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

D) Communicable Disease Screening:

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
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Name of Physician (Please print)	() Phone
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Address	City/State	Zip
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Emergency Contact Information