

*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 \_\_\_\_\_ immunization record from your pediatrician or family physician may be necessary to accurately transfer dates to this record.

Vaccine	Record of Data					
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>
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.***

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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**