BETHEL COLLEGE ATHLETIC TRAINING EDUCATION PROGRAM
RECOMMENDED MEDICAL EXAMINATION FORM

When completed, this form should be returned to the Bethel College ATEP Director.

STUDENT INSTRUCTIONS: EVERY ATHLETIC TRAINING STUDENT enrolling at **Bethel College** is required to present a report of his/her medical history and signed physical examination form. The student is to fill in all of the personal data and medical history below. Your physician can help you with the medical history.

TYPE or BLOCK PRINT the INFORMATION BELOW:

Name_____ Race_____ Male_____ Female_____
Last First Middle

Age_____ Date of Birth_____ Enrolling as: Freshman_____ Sophomore_____ Junior_____ Senior_____

Home address_____
Street City State (country) Zip

MEDICAL HISTORY (To be filled out by the student and checked with physician before examination)

FAMILY HISTORY:

Relation	Age	State of Health	If Deceased, Cause of Death	Age at Death	Has any blood relation had: check each item		
Father					Yes	No	Asthma, Hay Fever
Mother					Yes	No	Allergy to Drugs
Brothers					Yes	No	Hypertension
					Yes	No	Diabetes
					Yes	No	Heart Trouble
Sisters					Yes	No	Kidney Trouble
					Yes	No	Rheumatism (Arthritis)
					Yes	No	Sickle Cell

Have you ever had or have you now:

Yes	**No**	Albumin in urine	**Yes**	**No**	Fainting Spells	**Yes**	**No**	Pleurisy
Yes	**No**	Arthritis	**Yes**	**No**	German Measles	**Yes**	**No**	Poliomyletis
Yes	**No**	Anemia	**Yes**	**No**	Hay Fever	**Yes**	**No**	Rectal Trouble
Yes	**No**	Appendicitis	**Yes**	**No**	Frequent Headaches	**Yes**	**No**	Rheumatic Fever
Yes	**No**	Asthma	**Yes**	**No**	Heart Murmur	**Yes**	**No**	Scarlet Fever
Yes	**No**	Back Trouble	**Yes**	**No**	Heart Trouble	**Yes**	**No**	Sinusitis
Yes	**No**	Bloody Urine	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Skin Disorder
Yes	**No**	Chicken Pox	**Yes**	**No**	Histoplasmosis	**Yes**	**No**	Spitting Blood
Yes	**No**	Chronic Cough	**Yes**	**No**	Infectious Hepatitis	**Yes**	**No**	Tendency to Bleed
Yes	**No**	Convulsions	**Yes**	**No**	Inf. Mononucleosis	**Yes**	**No**	Thyroid Trouble
Yes	**No**	Deafness	**Yes**	**No**	Jaundice	**Yes**	**No**	Tonsillitis
Yes	**No**	Diabetes	**Yes**	**No**	Kidney Trouble	**Yes**	**No**	Tuberculosis
Yes	**No**	Duodenal Ulcer	**Yes**	**No**	Measles	**Yes**	**No**	Venereal Disease
Yes	**No**	Colitis	**Yes**	**No**	Meningitis	**Yes**	**No**	Whooping Cough
Yes	**No**	Earache	**Yes**	**No**	Migraine	**Yes**	**No**	Other Disorders
Yes	**No**	Encephalitis	**Yes**	**No**	Mumps	**Yes**	**No**	

Other illnesses or complaints (Please list)_____

Allergies to drugs, foods, plants, others_____

Medications taken regularly_____

TO THE EXAMINER: The Athletic Training Education Program requires each student/personnel to have a physical examination at the time of application or employment within the program. Please identify any physical and/or mental limitations which may interfere with participation in prevention, evaluation, treatment and rehabilitation of injuries/illnesses during clinical and field experiences in various health care settings. Participation may include lifting such as patient transport.

PHYSICAL EXAMINATION

Student's Name_____Date of Exam_____

_____

Blood Pressure Pulse Weight Height

IMMUNIZATIONS (Please State the Year Received)

The following tests/immunizations are required for ATEP student/personnel.

EXAMINATION	NORMAL RANGE	ABNORMAL RANGE	COMMENTS
Hemoglobin	**Date** _____ **Signature** _____ **Agency** _____	**Date** _____ **Signature** _____ **Agency** _____	**Required.**
TB(two step): Mantoux #1 (date): _____ **Result:** _____ **Mantoux #2 (7-21 days after #1):):**_____ **Result:** _____ **Agency**_____ **Repeat TB (yearly) 1 (date):**_____ **Result:** _____ **Agency**_____			**Required.** **Further documentation and chest X-Ray required if positive.**
Measles **Mumps MMR** **Rubella**	**MMR#1**_____ **MMR#2**_____ **(Date) (Date)** **Agency:**_____		**Two measles immunizations are required for all persons born in or after 1957 or physician documentation of immunity necessary**
Tetanus (Td) - **(date):** _____ **Agency** _____			**Tetanus booster required within the last 10 years.**
Hepatitis B immunization Dates: #1_____ **#2**_____ **#3** _____ **Agency** _____			**Evidence of immunization or signed waiver required.**
Varicella: Have you had chicken pox? **Date** _____ **Immunization date** _____ **(or date of)** **Titer** _____ **(Chicken pox)** **Agency** _____ **Results:**			**Required.**
Polio Dates: #1_____ **#2**_____ **#3** _____ **#4**_____ **Agency** _____			**Required.**

Normal	Abnormal	Check appropriately and describe abnormalities
		Head, scalp, face
		Eyes
		Nose
		Mouth and Throat
		Teeth
		Neck
		Lungs
		Heart
		Breasts
		Abdomen
		Genitalia (Pelvic, if needed)
		Rectal
		Hernia
		Adenopathy
		Skin
		Disabilities

Vision—without glasses/with glasses

Right_____ Left_____

Color Vision_____

Hearing—Right_____

Left_____

_____

Physician's Signature

Please list any Physical Limitations_____

Mental Limitations; if so, please specifiy_____

Signature of Physician_____Degree_____Date_____