

**Wichita State University
Athletic Training Education Program
1845 Fairmount
Wichita, KS 67260-0016**

REPORT OF MEDICAL HISTORY

Last Name: _____ First Name: _____ MI: _____
SS#: _____ Gender (circle): F or M Date of Birth: _____
WSU Address: _____ Zip: _____ Phone: _____
Permanent Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
E-mail: _____ Cell Phone: _____

A) Family History: Please provide information about past family medical conditions.

Medical Condition:

| | | |
|---------------------|-----|----|
| Asthma | YES | NO |
| Allergies | YES | NO |
| Cancer | 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 |
| Ulcer Problems | YES | NO |
| Vision/Eye Problems | YES | NO |
| Other Conditions | YES | NO |

Family Member:

If yes, please specify: _____

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 | _____ |
| Ulcer Problems | 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 | / | / | / | / | / | / |
| Measles, Mumps, & Rubella (MMR) | / | / | / | / | / | / |
| Varicella (Chicken Pox) | / | / | / | / | / | / |
| Tuberculin (TB) | / | / | / | / | / | / |
| Hepatitis B | / | / | / | / | / | / |
| Other: | / | / | / | / | / | / |
| Other: | / | / | / | / | / | / |
| Other: | / | / | / | / | / | / |

D) Communicable Disease Screening:

The Wichita State University Athletic Training Education Program (ATEP) 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 rotations and field experiences during the time they are affected by the communicable disease and shall not return to clinical participation until allowed by the attending physician.

Wichita State University Student Health Service is required to report to the Kansas Department of Health the names of students who have certain communicable diseases. Students that contact a communicable disease are required to obey prescribed guidelines by his/her attending physician and the recommendations of the University affiliated physicians at Student Health Service. While a complete list of communicable diseases is not provided, Student Health Service advises all students to seek medical attention for any illness or disorder that could potentially be communicable in nature. The athletic training student must report to Student Health Service if one of the following diseases is suspected:

| | | | | | |
|-----------------------|--------------------------|--------------------------------------|-----------------------|------------------------------|-----------------------------|
| <i>Chickenpox</i> | <i>Conjunctivitis</i> | <i>Diarrhea - Infectious Disease</i> | <i>Diphtheria</i> | <i>Group A Streptococcal</i> | <i>Hepatitis A, B, or C</i> |
| <i>Herpes Simplex</i> | <i>HIV</i> | <i>Impetigo</i> | <i>Influenza</i> | <i>Lice (Pediculosis)</i> | <i>Measles (Rubeola)</i> |
| <i>Mumps</i> | <i>Meningitis</i> | <i>Pertussis</i> | <i>Rabies</i> | <i>Rubella</i> | <i>Scabies</i> |
| <i>Streptococcus</i> | <i>Tuberculosis (TB)</i> | <i>Typhoid Fever</i> | <i>Whooping Cough</i> | | |

Please indicate if you have a history of anyone of the communicable diseases listed above within the past year: YES NO

If yes, please indicate the specific disease and month.

Disease: _____

Month: _____

Disease: _____

Month: _____

Disease: _____

Month: _____

If yes, were you immunized for the communicable disease? YES NO

E) Please answer the following questions:

1. Do you have any allergies to food, medications, or anything else? YES NO

If yes, please specify: _____

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

I certify this individual is of sound health to perform the physical abilities in the Athletic Training Education Program. 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 injury and disease.

Signature of Physician _____ Date _____

()
Name of Physician (Please print) _____ Phone _____

Address _____ City/State _____ Zip _____

Emergency Contact Information

Last Name: _____ First Name: _____

Relationship: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Note: This information will NOT be released. Specific authorization from you is required.