SOUTHWESTERN COLLEGE ATHLETIC TRAINING EDUCATION PROGRAM

Student Physical Examination

Personal Information:

Name: _____ Date: _____

Address: _____

Phone: _(____)_____ Date of Birth: _____

Social Security #: _____ Sex: M F

Personal Medical History:

			Comments:
Allergies	Yes	No	_____
Alcohol/Drug Abuse	Yes	No	_____
Asthma	Yes	No	_____
Diabetes	Yes	No	_____
Epilepsy	Yes	No	_____
Fainting Spells	Yes	No	_____
Hearing Loss	Yes	No	_____
Hemophilia/Blood Disease	Yes	No	_____
Tuberculosis	Yes	No	_____

Physical Examination: (to be completed by a physician)

Date	_____	Age	_____
Height	_____	Weight	_____
BP	_____	Pulse	_____
Vision Right	_____	Left	_____

I have this day given (name)_____a careful physical examination and found her/him in _____health.

After this examination, do you believe that the health history and physical examination justify this individual undertaking the athletic training education program? YES NO

Does this individual meet the technical standards of the program? YES NO

If NO, can this individual meet the technical standards of the program with accommodations? YES NO

Comments:

_____

_____

_____

Physician's Name _____ Date_____

Address _____

Physician's Signature _____ Phone (____)_____

* **Physical examination form must be complete in its entirety and signed by the Physician. ***