

***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) | (      )<br>Phone |
|----------------------------------|-------------------|

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|         |            |     |
|---------|------------|-----|
| Address | City/State | Zip |
|---------|------------|-----|

### *Emergency Contact Information*