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 (circle): F or M Date of Birth: _____

WSU Address: _____ Zip: _____ Phone: _____

Permanent Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Cell Phone: _____

A) <u>Family History</u>: *Please provide information about past family medical conditions.*

<u>Medical Condition:</u>			**<u>Family Member:</u>**
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	_____

If yes, please specify: _____
_____
_____
_____

B) <u>Personal History</u>: *Please provide information about past personal medical conditions.*

<u>Medical Condition:</u>			**<u>Date:</u>**
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) <u>Immunization Record</u>: *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**					
	1st	**2nd**	**3rd**	**4th**	**5th**	**6th**
Diphtheria, Pertussis, & Tetanus, (DPT)	/	/	/	/	/	/
Tetanus or Tetanus-Diphtheria (Td)	/	/	/	/	/	/
Polio	/	/	/	/	/	/
Measles, Mumps, & Rubella (MMR)	/	/	/	/	/	/
Varicella (Chicken Pox)	/	/	/	/	/	/
Tuberculin (TB)	/	/	/	/	/	/
Hepatitis B	/	/	/	/	/	/
Covid-19	/	/	/	/	/	/
Influenza	/	/	/	/	/	/
Other:	/	/	/	/	/	/
Other:	/	/	/	/	/	/
Other:	/	/	/	/	/	/

D) <u>Communicable Disease Screening</u>:

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 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:

Chickenpox	*Conjunctivitis*	*Diarrhea - Infectious Disease*	*Diphtheria*	*Group A Streptococcal*	*Hepatitis A, B, or C*
Herpes Simplex	*HIV*	*Impetigo*	*Influenza*	*Lice (Pediculosis)*	*Measles (Rubeola)*
Mumps	*Meningitis*	*Pertussis*	*Rabies*	*Rubella*	*Scabies*
Streptococcus	*Tuberculosis (TB)*	*Typhoid Fever*	*Whooping Cough*	*Covid-19*	*Other:*

Please indicate if you have a history of any 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) <u>Please answer the following questions</u>:

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

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.

_____

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.