



## Student Health Assessment Form

*The Athletic Training Education Program requires that you have the following information completed by a healthcare practitioner 4 months prior to beginning the clinical program.*

Applicant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_  
 Vision R \_\_\_\_\_ L \_\_\_\_\_ Corrected: Y / N

### Medical Screening

|                         |                |              |
|-------------------------|----------------|--------------|
| <b>Skin</b>             | <b>E.N.T.</b>  | <b>Chest</b> |
| <b>Head/Neck</b>        | <b>Abdomen</b> | <b>Heart</b> |
| <b>Neck</b>             | <b>Hernia</b>  | <b>Lungs</b> |
| <b>Recommendations:</b> |                |              |

### Musculoskeletal Screening

|                                       | Normal | Abnormal Findings/recommendations |
|---------------------------------------|--------|-----------------------------------|
| Back stability/strength<br>45kg carry |        |                                   |
| U.E. ROM                              |        |                                   |
| U.E. Strength                         |        |                                   |
| U.E. Stability                        |        |                                   |
| L.E. ROM                              |        |                                   |
| L.E. Strength                         |        |                                   |
| L.E. Stability                        |        |                                   |
| Medications:                          |        |                                   |

**Based upon this assessment, it is my judgment that \_\_\_\_\_ is physically and emotionally able to perform the duties required of an Athletic Training Student.**

\_\_\_\_\_  
Examiner Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
License#

\_\_\_\_\_  
Applicant's Signature