

**BETHANY COLLEGE**  
**Athletic Training Educational Program**  
**Student Medical Record**

Complete Section I (Personal Information) and Section II (Medical History).

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**I. PERSONAL INFORMATION**

Date: \_\_\_\_\_

Name in full: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Local Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Street

\_\_\_\_\_

City

State

Zip

Home Address: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

Street

\_\_\_\_\_

City

State

Zip

Emergency Contact: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

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**II. MEDICAL HISTORY**

A. Circle disease or illness that you have had:

Chicken Pox

Asthma

Mononucleosis

Mumps

Hay Fever

Pneumonia

Hepatitis

Hypertension

Kidney Disease

Seizures/Epilepsy

Rheumatic/Scarlet Fever

Other Serious Illnesses: \_\_\_\_\_

Allergies (medicines, bee stings, etc.): \_\_\_\_\_

Operations/Dates (mo./year): \_\_\_\_\_

Injuries/Dates (mo./year): \_\_\_\_\_

List medication(s) taken on a regular basis: \_\_\_\_\_

\_\_\_\_\_

B. Immunizations (Bring shot record to physical exam):

1. Tetanus/diphtheria toxoid (Td) – (booster required every 10 years) – Date: \_\_\_\_\_

2. MMR vaccination: (required unless immune or have had 2 doses since 1<sup>st</sup> birthday) –

Dates: \_\_\_\_\_, \_\_\_\_\_ Titer \_\_\_\_\_

3. Hepatitis B vaccinations: Date #1: \_\_\_\_\_ #2: \_\_\_\_\_ #3: \_\_\_\_\_

Date of titer: \_\_\_\_\_

4. Varicella (Chicken Pox) Titer \_\_\_\_\_

5. Varicella vaccination: \_\_\_\_\_

(Titer required if immunization was received).

**III. PHYSICAL EXAMINATION (to be completed by physician)**

A. Medical

B. Musculoskeletal

1. Condition of:

1. Condition of:

Normal	Medical	Abnormal Findings	Normal	Musculoskeletal	Abnormal Findings
	Eyes			Neck	
	Ears			Back	
	Sinuses			Shoulder/Arm	
	Nose			Elbow/Forearm	
	Throat (adenoids & tonsils)			Wrist/Hand	
	Thyroid			Hip/Thigh	
	Sinuses			Knee	
	Nose			Leg/Ankle	
	Lungs			Foot	
	Heart				
	Murmurs				
	Blood Pressure				
	Pulse				
	Abdomen and Viscera				
	Genitalia/Hernia				
	Condition of Feet				
	Skin				
	Height				
	Weight				

2. Mantoux Tuberculin Skin Tests (two are required initially; one each year thereafter)

	<u>Dates Given</u>	<u>Dates Read</u>	<u>Results</u>
1a.	_____	_____	_____
1b.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Chest X-ray (if indicated): Date & results: \_\_\_\_\_

3. Comments/Recommendations:

Does the Athletic Training Student have any on-going health problem(s) that would interfere with performance in the clinical setting? \_\_\_\_\_

Date: \_\_\_\_\_ Physician Signature \_\_\_\_\_

Physician's Name (print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (        ) \_\_\_\_\_