Physical Examination for Minnesota State University Athletic Training Students

(Examinations for ATHLETIC TRAINING STUDENTS must be completed by a Medical Physician)

Name:____ ____/___/________ ____/___/________
(last) (first) (m) (date of birth) (date of examination)

HEIGHT **WEIGHT** **BLOOD PRESSURE** **HEART RATE**

VISION

Right 20/_________ Left 20/__________

Contact Lens: Yes No Color Blind: Yes No
If visually impaired please check:
B1 __ B2 __ B3 __

HEARING (Whispered Voice at 10 feet)

Right: _______Normal ______Abnormal

Left: _______Normal ______Abnormal

CLINICAL EVALUATION

Check each item in appropriate column, at right
Enter "N.E." If not evaluated.

Normal Abnor-mal

NOTES: Describe any abnormality in detail below, include results of any lab done.

1. SCALP, FACE, NECK, THYROID ____________________
2. NOSE and SINUSES ____________________
3. MOUTH (tongue, gingivae, teeth) ____________________
4. THROAT and TONSILS ____________________
5. EARS (tims and Ext. Canels) ____________________
6. EYES (pupils, EOM conjunct.) ____________________
7. LUNGS and CHEST (include breasts) ____________________
8. HEART (rhythm, sounds, murmurs) ____________________
9. ABDOMEN and VISCERA ____________________
10. HERNIA ____________________
11. ANUS and RECTUM (prostate if indicated)] ____________________
12. ENDOCRINE SYSTEM ____________________
13 G-U SYSTEM ____________________
14. UPPER EXTREMITIES ____________________
15. LOWER EXTREMITIES ____________________
16. FEET (flat, pain, infection) ____________________
17. SKIN, LYMPHATIC GLANDS ____________________
18. NEUROLOGIC ____________________
19. PELVIC (If deemed necessary) Menstrual Cycle ____________________
20, SURGERY(S) ____________________
21. SUFFICIENT POSTURAL AND NEUROMUSCULAR CONTROL to function as an allied health care provider (please explain not sufficient)

22. Immunization Record Verification: Minnesota Law (M.S. 135A.14) requires that all students born after 1956 and enrolled in a public or private post-secondary school in Minnesota be immunized against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions.

MMR (Measles, Mumps, Rubella) Month:_____________________Day:________________ Year:_____________________
Td or Tdap Diptheria & Tetanus (TD) Month:_____________________Day:________________ Year:_____________________

The above student does not have one or more of the required immunizations because s/he has (check all that apply) ☐ a medical problem that precludes the ___________ vaccine(s); ☐ not been immunized because of a history of ______________________ disease (s); ☐ shown laboratory evidence of immunity against ________________
Summary of defects and diagnosis: ____
____

Medications currently prescribed, etc ____
____

Drug Allergies: ____

CHECK REGARDING WORK IN A HEALTH CARE SETTING, INCLUDING LIFTING:

__________**NO RESTRICTIONS** __________**SPECIFIC RESTRICTIONS** __________**COMPLETE RESTRICTIONS**

SUGGESTED RESTRICTIONS OR RECOMMENDATIONS FOR REASONABLE ACCOMMODATIONS, IF ANY:

To my knowledge the above information is accurate and complete:

Physician's Signature____Date__________________

Print or Type:____
(Physician's Name) (Address) (Phone Number)