Wheeling Jesuit University
Athletic Training Program Physical Form

All Forms Must Be Completed and Returned before your clinical rotation site begins in the fall.

PLEASE PRINT CLEARLY

Name: (Last) _____ (First) _____ (Middle) _____ Sex: M __ F __

Date of Birth: (mo) _____ (day) _____ (yr) _____ Email you check regularly: _____

(Street Address) _____ (City) _____

(State or Country) _____ (Zip) _____ Home Telephone: [_____] _____

Please check: commuter ____ campus resident ____ Student Cell: [_____] _____

Year entering _____ Please check: Entering Fall Semester _____ Entering Spring Semester _____

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PLEASE PRINT CLEARLY

Emergency Contact Person: _____ Relationship: _____

(Street) _____ (City) _____ (State/Country) _____ (Zip) _____

Home Telephone: [_____] _____ Alternative Telephone Number: [_____] _____

Emergency contact email:
_____

Name of Family Physician/Health Care Provider: _____ Telephone: [_____] _____

(Street) _____ (City) _____ (State/Country) _____ (Zip) _____

ALL ATEP STUDENTS MUST PROVIDE PROOF OF HAVING MEDICAL INSURANCE COVERAGE.

This requirement is to ensure that all students will have access to medical care if needed. Your medical insurance information will be kept confidential and on file for scheduling medical referrals to outside physicians, outpatient treatment, emergencies, and/or participation in University athletics.

Insurance company/provider: _____ Policy No. _____ Group No. (if applicable) _____

YOU MUST ALSO PROVIDE A FRONT/BACK COPY OF YOUR INSURANCE CARD WITH THIS FORM.

STUDENT SIGNATURE REQUIRED IF AGE 18 OR OVER.

I hereby authorize the WJU Student Wellness Center to render services deemed necessary for my health and well-being. I grant permission for my transfer to an accredited hospital or other care facility if deemed necessary by the Dean of Student Development or his/her designee. I agree to be responsible for any expense in connection with the aforesaid, if my insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my treatment by their facility to the Wheeling Jesuit University Student Wellness Center for continuity of care.

Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE REQUIRED IF STUDENT IS UNDER THE AGE OF 18.

I hereby authorize the WJU Student Wellness Center to render services deemed necessary for my student's health and well-being. I grant permission for my student's transfer to an accredited hospital or other care facility if deemed necessary by the Dean of Student Development or his/her designee. I agree to be responsible for any expense in connection with the aforesaid, if my student's insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my student's treatment by their facility to the Wheeling Jesuit University Student Wellness Center for continuity of care.

Signature of parent/guardian: _____ Date: _____

PERSONAL HEALTH HISTORY TO BE FILLED OUT BY AT STUDENT

This information will be used only as an aid in the consideration of your health needs and will remain confidential among the appropriate healthcare professionals. PLEASE USE ADDITIONAL SHEETS OF PAPER IF NECESSARY.

Are you presently under any medical treatment? Yes ☐ No ☐
If *yes*, explain: _____

Are you taking any medications at present (prescription, nonprescription, inhaler)? Yes ☐ No ☐
If *yes*, explain: _____

Are you now receiving or have you ever received professional help for emotional or psychological problems? Yes ☐ No ☐
If *yes*, when: _____

Do you have a physical impairment such as paralysis, loss of vision, hearing, etc.? Yes ☐ No ☐
If *yes*, explain: _____

Do you have any sensitivity to food, medicine, or environmental contact? Yes ☐ No ☐
If *yes*, explain: _____

Have you ever had a head injury or concussion? Yes ☐ No ☐
If *yes*, explain and give dates: _____

Has a physician ever denied or restricted your participation in sports for any health problems? Yes ☐ No ☐
If *yes*, explain: _____

Have you ever had, or do you currently have:

☐ Chicken Pox	☐ Nervous Tendencies	☐ Rheumatic Fever	☐ Heat Related Illness
☐ Heart Disease	☐ Mononucleosis	☐ Tuberculosis	☐ Asthma, Hay Fever, or Hives
☐ Hepatitis	☐ Diabetes	☐ Convulsions or "black outs"	☐ Eating Disorders
☐ Seizures	☐ Heart Murmur	☐ Pregnancies - Date of last menstrual period: _____	

☐ Loss of function of a "paired organ" (eye, ear, testicle, ovary, kidney)
☐ NONE OF THE ABOVE

If you checked any of the above, please provide further information: _____

_____

Dates of significant injuries or operations or medical admissions to hospitals: ☐ NONE _____

_____

Personal Habits (please indicate use of any of the following):
☐ Smoking tobacco ☐ Smokeless Tobacco ☐ Alcohol ☐ Dietary Supplements ☐ Dental appliances ☐ NONE

ALLERGIES/REACTIONS:
Latex: _____ Food: _____

Dyes: _____ Medication: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I also state that a licensed Physician or Nurse Practitioner completed my Physical Form.

Student Signature: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

(If under the age of 18)

A PHYSICIAN MUST COMPLETE, SIGN, AND DATE THIS FORM.

PLEASE PRINT
STUDENT NAME: _____ _____ _____
Last First Middle Initial

Family history:
Among your immediate relatives (parents, siblings and grandparents), is there any history of, or present illness from, any of the following:

☐ Cancer ☐ Diabetes ☐ Asthma, Hay Fever, or other Allergies
☐ Heart Disease ☐ Marfan's Disease ☐ Sudden death under age 50 from non-trauma cause

Please explain any of the marked replies: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

LIST MEDICATIONS: _____

General Exam

Normal	**Abnormal**	**Notes of Abnormality**
_____Skin	_____	
_____Hearing	_____	
_____Head	_____	
_____Ear, Nose, & Throat	_____	
_____Neck: Thyroid	_____	
_____Cardiovascular	_____	
_____Lungs	_____	
_____Breasts	_____	
_____Abdomen	_____	
_____Genitalia	_____	
_____Menstruation	_____	
_____Back & Extremities	_____	
_____Reflexes	_____	

Orthopedic Exam

Normal	**Abnormal**	**Notes of Abnormality**
_____Cervical Spine	_____	
_____Thoracic Spine	_____	
_____Lumbar Spine	_____	
_____Shoulders	_____	
_____Elbows	_____	
_____Wrists, Hands, Fingers	_____	
_____Hips/Pelvis	_____	
_____Knee	_____	
_____Ankles, Feet, Toes	_____	
_____General Flexibility	_____	

Comments:_____
_____
_____
_____
_____
_____

Check only ONE of the boxes below:

☐ I certify that I have examined the student and have found ***no obvious condition(s)*** that would prevent him/her from meeting the criteria listed in the physical portion of the Technical Standards for Admission to the ATP program at Wheeling Jesuit University.

☐ I certify that I have examined the student and have found ***an obvious condition(s)*** that would prevent him/her from meeting the criteria listed in the physical portion of the Technical Standards for Admission to the ATP program at Wheeling Jesuit University. I recommend that the student contact notify the Program Director and work with the University's Disability Services to discuss accommodation options.

Physician Signature: _____ Date: _____

Wheeling Jesuit University
Department of Athletic Training
Immunization Records

Name:_____ Date of Birth: _____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER OR ATTACH COPIES OF OFFICIAL IMMUNIZATION CAN BE PROVIDED INSTEAD
All information must be in English

REQUIRED (Mandatory) Immunization for University Students

Vaccine Enter date each immunization was given

Measles (Month, Day, Year)	#1	#2	Documentation of two doses at least 28 days apart after 12 months of age.

Tdap (Tetanus, Diphtheria, Accellular Pertussis) (Month, Day, Year)	#1	One dose since 2005 regardless of interval since last Td (Tetanus, Diphtheria) then Td booster every 10 years

Hepatisis B (Month, Day, Year)	#1	#2	#3

Hepatitis B is a serious infection that affects the liver and is easily spread through contact with blood and body fluids. A 3 dose series of vaccination can provided long term protection against hepatitis B and its potential acute and chronic consequences. More information about hepatitis B can be obtained at www.cdc.gov

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RECOMMENDED (Optional) Immunization for University Students

Meningococcal (Quadrivalent polysaccharide vaccine)	#1

Meningococcal disease is a serious bacterial infection that affects the brain and spinal cord. Neisseria meningitides bacteria are spread through the exchange of respiratory and throat secretions. College freshmen, especially those living in residence halls, are at an increased risk of meningococcal disease relative to other people their age. The Advisory Committee on Immunization Practices (ACIP) suggests that college age students receive the vaccine less than 5 years before starting college. More information about meningococcal can be obtained at www.cdc.gov.

I, (print name) _____ have been informed and understand the risks of declining the meningococcal vaccine. I hereby release Wheeling Jesuit University, its officers, trustees, and employees from any and all liability that may arise directly or indirectly as a result of my choice not to receive the meningococcal vaccine.

To the Health Professional

Please review the requirements, administer the needed immunizations, and sign below to validate.

Signed_____ Title _____ Date _____

Wheeling Jesuit University
Department of Athletic Training
Technical Standards for Admission

The Athletic Training Program at Wheeling Jesuit University is a rigorous and intense academic program that places specific requirements and demands on the students enrolled in the program. The objective of this program is to prepare graduates to enter a variety of employment settings and to render care to a wide spectrum of people engaged in physical activity. The technical standards set forth by the ATP establish the essential qualities considered necessary for students admitted to this program to achieve the knowledge, skills competencies of an entry-level athletic trainer, as well as meet the expectations of the program's accreditation agency (Commission on Accreditation of Athletic Training Education [CAATE]) These technical standards are the basic physical, cognitive, and psychosocial skills and abilities that are required for all students who choose to major in Athletic Training at Wheeling Jesuit University. Should a student not be able to fulfill the requirements of the Technical Standards with or without reasonable accommodations, the student will be prohibited admission into the ATP program. In addition, compliance with the ATP's technical standards does not necessarily guarantee a student's eligibility for the Board of Certification exam.

The following standards must be demonstrated by the Wheeling Jesuit University ATP student:

1. The mental capacity to assimilate, analyze, synthesize, and integrate concepts and problem solve to formulate assessment and therapeutic judgments and to be able to distinguish deviations from the norm.
2. Sufficient postural and neuromuscular control, sensory function, and coordination to perform appropriate physical examinations using accepted techniques; and accurately, safely and efficiently use equipment and materials during the assessment and treatment of patients.
3. The ability to communicate effectively and sensitively with patients and colleagues, including individuals from different cultural and social backgrounds; this includes, but is not limited to, the ability to establish rapport with patients and communicate judgments and treatment information effectively. Students must be able to understand and speak the English language at a level consistent with professional practice.
4. The ability to record the physical examination results and a treatment plans clearly and accurately.
5. The capacity to maintain composure and continue to function well during periods of high stress.
6. The perseverance, diligence and commitment to complete the athletic training program outlined and developed at Wheeling Jesuit University.
7. Flexibility and the ability to adjust to changing situations and uncertainty in clinical situations.
8. Affective skills and appropriate demeanor and rapport that relate to professional education and effective quality patient care.

Should a student request the need for accommodations in order to meet the technical standards, the Program Director will be notified, and, in conjunction with the University's Disability Services, a review of the request will commence. Determinations for specific accommodations will be implemented on a case by case basis. The University reserves the right to deny, or refuse accommodations that are deemed unreasonable. No accommodations will be made if clinician/patient safety, the educational integrity of the program (including coursework, educational process of the student, internships and clinical sites), or the University could be jeopardized. Each student must meet the technical standards for all courses, throughout enrollment in the program.

Student Statement: Check ***only one*** box

□ I confirm that I have read and understand the technical standards listed above and to the best of my knowledge believe I am able to meet each of these standards ***without accommodation.*** I also understand that should I become unable to meet these standards with or without accommodation, I will not be able to enroll or remain in the program.

(OR)

□ I confirm that I have read and understand the technical standards listed above and to the best of my knowledge believe I am able to meet each of these standards ***with accommodations.*** I will contact the Program Director and the University's Disability Services to have the need for accommodation evaluated. I understand in some cases accommodation might not be possible, and the University reserves the right to deny any requests deemed unreasonable. I also understand that should I become unable to meet these standards with or without accommodation, I will not be able to enroll or remain in the program.

Student Signature_____ Date_____