East Texas Baptist University-Athletic Training Program
Medical History Summary
(This completed form must be returned to the Athletic Training Program prior to admission)

Name: _____Sport(s): _____
DOB: ____/____/_____ SS# _____-_____-_____ Cell phone: (___)_____

Guardian's Name(s): _____
Mailing Address: _____
City: _____ State: _____ Zip _____ Phone: (___)_____

Medical History (check all that apply)

- ☐ Have you ever had a significant injury and/or surgery that required loss of playing time?

Explain:_____

- ☐ Dental issues requiring a special mouthpiece
- ☐ Head injury or concussion
- ☐ Loss of consciousness
- ☐ Heat related illness
- ☐ Missing organs
- ☐ Heart problem
- ☐ High blood pressure
- ☐ Chest pains
- ☐ Gastrointestinal problems
- ☐ Urinary tract problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Sickle-cell trait
- ☐ Glasses/Contacts
- ☐ Severe headaches
- ☐ Dizziness, seizures
- ☐ Fainting
- ☐ Ears problems
- ☐ Nasal Problems
- ☐ Eating Disorders
- ☐ Orthotics for shoes
- ☐ Back Injuries

Elaborate on checked boxes:

_____

Medications taken consistently: _____
Allergies:_____
Date of last tetanus shot: _____Blood type: _____Date of last menstrual cycle:_____

Permission is hereby granted to the athletic training staff to use their best judgment in securing medical aid and ambulance service. Permission is also granted to any doctor to proceed with any needed medical care for the above named athlete In the event of significant accidental injury requiring medical treatment, I understand that an attempt will be made by the athletic training staff or the attending physician to contact me in the most expeditious manner possible. In the event I am unable to be reached, any treatment for the best interest of the above named athlete may be given. I hereby authorize any necessary medical provider to file claims on my behalf for injuries sustained by the above athlete under my medical policy.
Your signature verifies that the above information is correct to the best of your knowledge and that all relevant documentation concerning medical treatment and insurance information has been reviewed appropriately.

Guardian Signature:_____ Date:_____

Athlete Signature: _____ Date: _____

East Texas Baptist University

Athletic Training Program Physical Examination Summary

Name:_____ Date of Exam:_____
Gender: M F Age:_____ Ht.:_____ Wt.:_____ B/P: _____/_____ Pulse:_____

Skin _____
Dental/Mouth _____
Head _____
Nose/Throat _____
Eyes
- Rt _____
- Lt _____

Ears _____
Neck_____
Lungs
- Rt _____
- Lt _____

Heart _____

Abdomen
- Liver_____
- Spleen_____
- Kidneys_____
- Stomach_____
- Bowels_____

Hernia_____
Lymphatic
- Cervical_____
- Axillary_____
- Femoral_____

Genitalia_____

Orthopedic Screening

Shoulder
- Abd _____
- Add _____
- Flex_____
- Ext _____
- Int Rot_____
- Ext Rot _____
- Stability_____

Hip
- Ext _____
- Flex_____
- Abd _____
- Add _____
- Stability_____

Posture
- Shoulders _____
- Spine _____
- Pelvis _____

Knee
- Flex_____
- Ext _____
- MCL_____
- LCL_____
- PCL_____
- ACL_____

Ankle
- Plantar Flexion_____
- Dorsiflexion_____
- Inversion_____
- Eversion_____

Trunk/Neck
- Flex_____
- Ext _____
- Rot _____
- Lat Flex _____

☐ No participation:_____
☐ Limited Participation: _____

☐ Clearance withheld _____
☐ Cleared for Participation _____

Comments: _____

This physical exam must be completed by a licensed physician, physician's assistant or nurse practitioner.

_____ _____
MD / PA / NP Signature Date

_____
License / Certification Number