# LIBERTY UNIVERSITY ATHLETIC TRAINING PROGRAM

Athletic Training Student Health Data Form

**SECTION I (To be completed by student).**

1. Name:_____
   Last First Middle Initial
2. Home Address:_____
   Street City State Zip
3. Local Address:_____
   Street City State Zip
4. Social Security Number:_____ 5. Date of Birth:_____
6. Home Phone: (____)_____ Local Phone: (____)_____
7. School e-mail:_____ Other e-mail:_____
8. Name and Telephone of Persons to be Notified in Case of Illness or Emergency:_____

**Personal Health History: Have you had any of the following (circle "Yes" or "No")**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | YES | NO | Boils | YES | NO | Red Measles | YES | NO |
| Anemia | YES | NO | Post HIV Antibod. Test | YES | NO | Mumps | YES | NO |
| Chicken Pox | YES | NO | Cancer/Tumors | YES | NO | Respiratory Problem | YES | NO |
| Back Problems | YES | NO | Kidney Problems | YES | NO | Hepatitis | YES | NO |
| Heart Problem | YES | NO | Alcohol/Drug Problems | YES | NO | Headaches | YES | NO |
| Tuberculosis | YES | NO | Epilepsy or Seizures | YES | NO | German Measles | YES | NO |
| Vision Problems | YES | NO | Mental/Nervous Condition | YES | NO | Ulcers | YES | NO |
| Diabetes | YES | NO | HIV/AIDS | YES | NO | Skin Rash | YES | NO |
| Hearing Loss | YES | NO | Arthritis | YES | NO | Surgeries | YES | NO |

**Please Explain any "YES" answers**:_____

_____

_____

**SECTION II (To be completed by a licensed health care provider.)**

9. TB SCREEN (within last 12 months) Date of Test_____ Findings_____

| **IMMUNIZATIONS:** | **MONTH/DAY/YEAR** | **REQUIREMENTS** |
|---|---|---|
| 10. TETANUS | _____ | A Booster within the last 10 years. |
| 11. MEASLES (MR or MMR) | _____ | Students born on or after 1/1/57 must show proof of immunity to measles (physician validated HX or serologic confirmation). |
| 12. MUMPS (MMR) | _____ | Students born on or after 1/1/57 must show proof of Mumps vaccination (physician validated HX or serologic confirmation). |
| 13. RUBELLA (MR or MMR) | _____ | All students must show proof of vaccination or serologic confirmation. |

# LIBERTY UNIVERSITY ATHLETIC TRAINING PROGRAM

Athletic Training Student Health Data Form

14. HEPATITIS B (HBV) **MONTH/DAY/YEAR** **All students are required to show proof of Hepatitis B Vaccine.**

1st _____

2nd _____

3rd _____

Titre _____ Hepatitis B titer may be required after the series of immunizations is complete.

15. **RECOMMENDATIONS:**

Check one:

_____ No history or physical findings on this exam would prohibit this student from participating in patient care.

_____ This student should have the following health problems evaluated or treated before providing patient care. (Comments below.)

_____ This student has health problems that prohibit him or her from providing patient care. (Comments below)

Specific Comments:_____

_____

_____

**Signature of Licensed Health Care Provider**: _____

Signature Date

Provider's Name: _____

Print Name

Address: _____

Street

_____

City State Zip

Phone: (_____) _____

---

**Please upload this form and your vaccination records to the Initial Application App:**

**https://apex.liberty.edu/apex/banprd/f?p=253:14:::NO:RP:FORM_NAME:ATH_TRAINING_SEC_APP**

**If you any issues please contact the Athletic Training Program Director, mjgage@liberty.edu**