

# 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 \_\_\_\_\_

<b><u>IMMUNIZATIONS:</u></b>	<b><u>MONTH/DAY/YEAR</u></b>	<b><u>REQUIREMENTS</u></b>
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)	_____	<u>All students</u> must show proof of vaccination or serologic confirmation.

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14. HEPATITIS B (HBV)

MONTH/DAY/YEAR

**All students are required to show proof of Hepatitis B Vaccine.**

1<sup>st</sup> \_\_\_\_\_

2<sup>nd</sup> \_\_\_\_\_

3<sup>rd</sup> \_\_\_\_\_

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: (\_\_\_\_\_) \_\_\_\_\_

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**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](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](mailto:mjgage@liberty.edu)**