KENT STATE UNIVERSITY
ATHLETIC TRAINING PROGRAM
ATS PHYSICAL CLEARANCE

NAME _____ BANNER ID NUMBER _____

DATE OF BIRTH _____ DATE _____

Personal background and History

1. Please list any family history of medical problems:

_____

_____

_____

_____

_____

_____

2. Please list any chronic medical problems that do or may require medical attention:

_____

_____

_____

_____

_____

3. Please list all surgeries (and approximate date) that you have experienced since time of birth:

_____

_____

_____

_____

_____

4. Please list all medications you are currently taking for chronic conditions:

_____

_____

_____

5. Please list all known drug allergies:

_____

_____

ATS Signature: _____ **Date**: _____

Examination

Height: ....._____
Weight: ....._____
Bp: ..... _____/_____
Pulse: ....._____
Respirations: .... _____
Vision: right ... _____/_____
Vision: left..... _____/_____
Correction:....._____

	NORMAL	ABNORMAL
HEAD	_____	_____
EYES	_____	_____
EARS	_____	_____
NOSE	_____	_____
THROAT/MOUTH	_____	_____
NECK	_____	_____
HEART	_____	_____

	NORMAL	ABNORMAL
LUNGS	_____	_____
ABDOMEN	_____	_____
BACK	_____	_____
EXTREMITIES	_____	_____
NEUROLOGICAL	_____	_____
HERNIA (MALES)	_____	_____

IMMUNIZATION RECORDS MUST BE ATTACHED TO THIS PHYSICAL CLEARANCE

COMMENTS: _____

_____

RECOMMENDATIONS OR RESTRICTIONS: _____

_____

_____

I have reviewed the TECHNICAL STANDARDS Document attached to this form and confirm that this student is qualified to perform in the Athletic Training Program at Kent State University effective the below listed date.

Physician's Signature: _____ Date: _____