The University of Southern Mississippi
Athletic Training Education Program
Physical Examination Information

Name_____ **Date of Exam:**_____
(last) (first) (middle initial)

SS#_____ **DOB** _____/_____/_____

Lab: Sickle Cell: _____ **HCT:** _____ **URINE ANALYSIS:**_____

	Findings/Results			Findings/Results
Height			**BP**	
Weight			**Vision**	
Auditory				
PHYSICAL FINDINGS	**Normal/Abnormal**		**ORTHOPEDIC**	**Normal/Abnormal**
HEENT			**Neck**	
DENTAL			**Shoulders**	
HEART			**Elbows**	
LUNGS			**Wrist/Hand**	
ABDOMEN			**Back**	
HERNIA			**Pelvic/Hip**	
GENITALIA			**Knees**	
SKIN			**Ankles**	
NEUROLOGIC			**Feet**	
IMMUNIZATIONS	**Current: (circle)**		**DATE of (UPDATED) IMMUNIZATION**	
TB Skin Test	**YES NO**			
Tetanus	**YES NO**			
Hepatitis B*	**YES NO**			

*HEPATITIS-B WAIVER MAY BE SUBMITTED IN PLACE OF IMMUNIZATION RECORD

PHYSICAL EXAM PASS: _____ **YES** _____ **NO**

Comments: _____

I certify the named individual is both mentally and physically fit to meet the demands of fulfilling the technical standards of the clinical education and curriculum for the allied health care profession of athletic training, (with attention to the visual, auditory, ambulatory coordination, and muscular strength necessary to provide quality patient care and safety). I further certify that this individual can meet the technical standards with little to no accommodation; this includes a review a whether the accommodations requested are reasonable, taking into account whether accommodation would jeopardize clinician/patient safety, or the educational process of the student or the institution, including all coursework, clinical experiences and internships deemed essential to graduation.

_____
MD Signature

Medical Office Stamp