ARKANSAS STATE UNIVERSITY

STUDENT HEALTH RECORD

INSTRUCTIONS: PLEASE PRINT--USE PEN OR TYPE. PLEASE READ CAREFULLY!

A Student Health Record is required for all students enrolled in the Athletic Training Program. This will become part of your confidential health record while enrolled at Arkansas State University and will be kept in your clinical education folder.

This information is desired in the event you should experience any health problems while you are a student and to fulfill the health and safety requirements of our clinical education sites. It has no bearing on your academic work. Therefore, do not hesitate to record all previous or present illnesses or symptoms.

- Please complete the *Personal Health History* form **yourself**.
- Have a physician complete the *Physical Examination* form. **Note: Be sure both sides are completed and the signature is given.**
- Have your **physician fill out and sign** forms for TB, MMR, and Hepatitis B **or attach proof** of immunization or lab evidence of immunity
- If you have not started and are planning to start, or have started the Hep B vaccination series, you only need to fill out the *Hep B Vaccination* form for the vaccinations you have already received. Please turn in documentation as you receive further vaccinations.
- Fill out the *Refusal of Hepatitis B Vaccine* form **if you choose not to get vaccinated for Hepatitis B**. This may eliminate the possibility of your being assigned to clinical education sites that require this vaccination.
- Complete the *Health Insurance Report* form, including a copy of the front and back of your insurance card.
- Make copies of all of these forms and place the originals in your Clinical Education Handbook. You will need your originals to make copies for your clinical sites. (The Clinical Education Team will not be making copies of these forms for you for your clinicals.) **Never give a clinical site your originals.**

PLEASE RETURN THE *COPIES* OF THE FORMS TO:

Dr. Carlitta Moore
Clinical Coordinator
Master of Athletic Training Program
Arkansas State University
P.O. Box 910
State University, AR. 72467

ARKANSAS STATE UNIVERSITY

PERSONAL HEALTH HISTORY
(To be completed by the student)

Name _____ Date _____
(Last) (First) (Middle)

Student Id # _____ Age _____

Place of Birth _____ Date of Birth _____

If there is a family history of any of the following disease(s) please check:

____ Diabetes ____ Cancer ___ Seizures ___ Heart trouble

____ High blood pressure ___ Blood disease

Describe any serious illness, injury, or operation you have had (in chronologic order) giving nature of condition, hospital name and location, date and any persistent after effects:

_____

_____

Are you sensitive/allergic to any medication or other substance?

_____

Please list any medications or special forms of therapy you use regularly:

_____

_____

Give date of last immunization against:

Diphtheria _____ Tetanus toxoid _____
Smallpox _____ Polio _____

Have you had either the clinical illness or immunization against: (If yes, include date in the appropriate box):

Disease	Immunization Date Dose #1	Immunization Date Dose #2	Immunization Date Dose #3	Illness Date	Lab Test Proving Immunity Date
Regular Measles (Rubeola) (MMR)					
Hard Measles (Rubella) (MMR)					
Mumps (MMR)					
Chicken Pox					
Hepatitis B					

Are you now being treated for any conditions? Yes ____ No ____ if so, what?

_____

_____

Describe any condition or diagnosis which may require accommodations during clinical experiences due to a physical, psychological or learning disability:

_____

_____

_____

_____

Student Name (PLEASE PRINT)

_____ _____

Student's Signature Date

ARKANSAS STATE UNIVERSITY

PHYSICAL EXAM

(To be completed by a physician)

Students Name: _____ Date: _____

Sex	Height	Weight	Pulse	Blood Pressure

Has student been your patient: ___ > 1 year ___ < 1 year ___ this is first visit

History: Are you aware of any serious illnesses or injuries? If so please describe:

_____

_____

Are there abnormalities of the following system? Describe fully. Use additional sheet if needed.

	NO|YES		NO|YES
1. SHEENT	___|___	5. Genitourinary	___|___
2. Respiratory	___|___	6. Musculoskeletal	___|___
3. Cardiovascular	___|___	7. Metabolic/Endocrine	___|___
4. Gastrointestinal	___|___	8. Neurological	___|___

If yes, please describe: _____

_____

To your knowledge is this person now under treatment for any medical or psychological condition?

Yes _____ No _____If yes, please comment: _____

_____

Physician's Signature _____ Date _____

Physician's Name _____ Telephone _____

(PLEASE PRINT)

ARKANSAS STATE UNIVERSITY

TB SKIN TEST IMMUNITY REPORT

Student Name (PLEASE PRINT) _____

PLEASE NOTE: THIS TEST CANNOT BE THE SELF-READ "TINE" TEST. IT MUST BE AN INTRADURAL TYPE TEST.

TUBERCULIN SKIN TEST TYPE: _____

TEST:

Date Given: _____

Date Read: _____ Reaction: _____

_____ _____

Nurse's or Physician's Signature Date

Physician or Clinic Address:

_____

_____

Physician or Clinic Phone Number: _____

Please Return To:

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Clinical Coordinator
Athletic Training Program
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State University, AR. 72467