WILLIAM PATERSON UNIVERSITY
MASTER OF SCIENCE IN ATHLETIC TRAINING
STANDARD PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

Name:___________________________ Banner ID#_________________ Date of Birth__________

Please note that this physical examination information will be confidential. Only the Athletic Training Program faculty will have access to this information. This document will remain in the applicant's files in the Program Director's office.

<u>Medical History</u> (Please fill out the following information. Do not leave items blank. If an item does not pertain to you, write "N/A" or "None.")

<u>Please note any ALLERGIES that you may have:</u>

Insect stings____ Bleach____ Iodine____ Alcohol____ Tape____ Prewrap____ Tape Adherent____ Latex____
Medications (list)____

Food (list)____

Other (list)____

Do you require glasses or contact lenses for vision correction?__________ If yes, which do you wear?__________________

Do you have a history of asthma?___________ If yes, do you use an inhaler?________________

Do you have a history of diabetes?___________ If yes, are you insulin dependent?____________

Record of illness: Arthritis___ Bronchitis___ Epilepsy___ Hepatitis___ Hernia___ Heat Illness___

Other (please list)____

Are you currently taking any medications?_____________
If yes, list the medications and note for what condition each medication is taken.
____

Please list all musculoskeletal/orthopedic injuries/conditions which you have had, including date of injury, surgical procedures, and/or rehabilitation for each injury/condition.
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Please comment on any other physical conditions that you have that you should disclose.
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<u>Vaccinations:</u> You must attach a copy of your vaccination record from your physician to this form in addition to filling out the information below.

Required:
MMR Vaccine – 2 doses of each required: Dose #1 ___/___/___ Dose #2 ___/___/___
Or Titer date:___/___/___ Copy of lab report **must** be attached □

Hepatitis B series*: Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
Or Titer date:___/___/___ Copy of lab report **must** be attached □

Meningitis___/___/___ (required if live on campus)

Covid-19: Dose #1 ___/___/___ as indicated, Dose #2 ___/___/___ Brand Name:___________________

Recommended:
Annual Flu Vaccine: ___/___/___ (most recent date completed)

Hep A: Dose #1 ___/___/___ Dose #2 ___/___/____

Tetanus Vaccine ___/___/___ (within last 10 years)

Mantoux (TB) ___/___/___

TDap ___/___/___

***Hepatitis B Vaccine Declination:**
(fill out only if you have not begun nor completed your Hepatitis B series doses)

I (student name) _____________________________, understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been advised by William Paterson University to be vaccinated with hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I should arrange to receive the vaccination series.
I declare the above information to be true to the best of my knowledge.

_______________________________ _______________________
Applicant Signature Date

Physical Examination **(To be completed by a physician MD/DO)**

Pulse: _________ Blood Pressure: _________Respirations: _________ Pulse Oximetry_________

EENT Evaluation:

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Thorax Evaluation:

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Abdominal Evaluation:

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Orthopedic Evaluation:

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Vaccination Review: ________ Initial by MD/DO

Comments:

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____

This individual is [ ] Cleared [ ] not Cleared [ ] Cleared pending

____
to perform the duties of an Athletic Training Student.

_____________________________ _____________________
Physician (MD/DO) Signature Date