MURRAY STATE UNIVERSITY
Athletic Training – Sports Medicine
ATHLETIC TRAINING EDUCATION PROGRAM PHYSICAL EXAM

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE NAME:** _____

DATE OF BIRTH: _____ **SS#:** _____ **GENDER:** _____

Height: _____ **inches /** _____ **ft** _____**in** **Weight:** _____**lbs** **Pulse:** _____ **Blood Pressure:** _____

Urinalysis: pH: _____ **Specific Gravity:** _____ **Glucose:** _____ **POS** _____ **NEG** **Blood:** _____ **POS** _____ **NEG** _____ **TRACE** **Protein:** _____ **POS** _____ **NEG** _____ **TRACE**

Vision Screening: Right 20/____ **Left 20/**____ **Both 20/**____ **Were contacts/glasses worn? Yes No**
Near Vision: Right 20/____ **Left 20/**____ **Both 20/**____ **Corrected: Right 20/**____ **Left 20/**____ **Both 20/**____

Orthopedic Exam:

HEAD/NECK: _____

SHOULDERS: Right: _____ **Left:** _____

ELBOWS/HANDS/WRISTS: _____

LOW BACK: _____

PELVIS/HIPS: _____

KNEES: Right: _____ **Left:** _____

ANKLES: Right: _____ **Left:** _____

LOWER LEGS/FEET/TOES: _____

Physician Exam:

HEART/LUNGS: _____

GENITALIA/HERNIA (Males): _____

I believe the aforementioned Applicant for the Athletic Training Education Program **has met / has not met** the requirements set forth in the Technical Standards and **will / will not** be able to perform the Essential Skills (with or without accommodation) necessary to succeed in the Athletic Training Education Program and be a successful entry-level certified athletic trainer. (See reverse for Technical Standards and Essential Skills.)

Disposition: _____ **Cleared** _____ **Hold** **Reason:** _____

Physician Signature: _____ **Date:** _____