University of Kentucky Professional Masters in Athletic Training Program
Physical Examination Form

A physical exam is required as part of student clinical requirements prior to entry into the Professional Masters in Athletic Training Program.

Name: _____ **Date of Birth**:____/____/____ **Gender:** ____ **Age:** _____

PHYSICAL EXAM (To be completed by physician or advanced practice provider)

Height _____ **Weight** _____ **Pulse** _____ **Blood Pressure** _____

Please examine this student as you would for a routine check-up, considering age, history and the fact the student will be working closely with patients as well as families and groups in the community. Indicate any abnormal findings.

Medical	Normal	Abnormal Findings
Eyes (vision)		
Ears, Nose, Throat		
Neck/Lymph Nodes		
Cardiovascular		
Lungs		
Abdomen		
Skin		
Neuro		
Psychiatric		
Musculoskeletal: ROM, strength, special tests		
Neck		
Spine/Back		
Shoulders		
Elbows		
Wrists/Hands		
Hips		
Knees		
Ankles/Feet		

Is the student cleared for participation in the clinical setting?

____ Cleared without restriction

____ Cleared with recommendation for further evaluation or treatment for: _____

____ Not cleared

I certify that I have examined this patient on this date and found him/her medically qualified to participate in the clinical requirements of this program. I also certify that I am a licensed physician or advanced practice provider.

Provider's Signature: _____ **Date:** _____

Provider's Address: _____

College of Health Sciences
Athletic Training