This form must be filled out by the physician that completed the physical and returned to the ATP Director by the patient. This form will be kept on record in the students permanent program file. Please return the completed physical **AND** this form to the ATP Director.

I _____ have completed a physical exam on
Print Physicians Name

_____ on _____.
Name of Patient **Date**

I affirm that the above named patient has been seen in my office and has passed the provided physical exam. He/She (Check One) □ **has** □ **does not have** the capacity to meet the Technical Standards for admission to the athletic training program that he/she provided to me with the physical exam form.

_____
Physicians Signature

Physician is to fill this section out **only** if the patient cannot meet the technical standards are they are written and requires modifications and/or accommodations.

Modifications/Accommodations needed: _____

_____

_____

_____

_____

_____
Physicians Signature

Piedmont College
Athletic Training Program
Technical Standards for Admission

The Athletic Training Program at Piedmont College is a rigorous and intense program placing specific requirements and demands on the students in the program. Each student admitted to the program must meet the technical standards established by the program's accrediting agency (CAATE) to verify they possess the essential qualities considered necessary to achieve the knowledge, skills, and competencies of an entry-level athletic trainer.

Compliance with the technical standards does not guarantee eligibility for the BOC certification exam.

Candidates for selection to the Athletic Training Program must demonstrate:

1. The mental capacity to assimilate, analyze, synthesize, integrate concepts and problem solve to formulate assessment and therapeutic judgments and to be able to distinguish deviations from the norm.
2. Sufficient postural and neuromuscular control, sensory function, and coordination to perform appropriate physical examinations using accepted techniques; and accurately, safely and efficiently use equipment and materials during the assessment and treatment of patients.
3. The ability to communicate effectively and sensitively with patients and colleagues, including individuals from different cultural and social backgrounds; this includes, but is not limited to, the ability to establish rapport with patients and communicate judgments and treatment information effectively. Students must be able to understand and speak the English language at a level consistent with competent professional practice.
4. The ability to record the physical examination results and a treatment plan clearly and accurately.
5. The capacity to maintain composure and continue to function well during periods of high stress.
6. The perseverance, diligence and commitment to complete the athletic training education program as outlined and sequenced.
7. Flexibility and the ability to adjust to changing situations and uncertainty in clinical situations.
8. Affective skills and appropriate demeanor and rapport that relate to professional education and quality patient care.

Athletic training program candidates are required to verify they understand and can meet these technical standards either with or without certain accommodations. The Academic Resource Center/Disability Support Services will evaluate a student who states he/she could meet the program's technical standards with accommodation and confirm that the stated condition qualifies as a disability under applicable laws.

If a student states he/she can meet the technical standards with accommodation, the College will verify that the standards can be met with reasonable accommodation; this includes a review of whether the accommodations requested 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.

Date of Physical Examination: _____

Name of MD/PA/FNP: _____

Name:			Today's Date:
Nickname or Preferred Name:			
Permanent Street Address:			City:
State:	Zip:	Cell Phone:	Date of Birth:
Piedmont College ID:		Piedmont College Email:	
Campus Box #:	Emergency Contact Name:		Emergency Contact Phone:

		YES	NO
1.	Have you had a medical illness or injury since your last check up or sports physical		
2.	Do you have an ongoing or chronic illness		
3.	Have you ever been hospitalized overnight		
4.	Have you ever had surgery		
5.	Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?		
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance		
7.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects		
8.	Have you ever had a rash or hives develop during or after exercise		
9.	Have you ever passed out during or after exercise		
10.	Have you ever been dizzy during or after exercise		
11.	Have you ever had chest pain during or after exercise?		
12.	Do you get tired more quickly than your friends do during exercise		
13.	Have you ever had racing of your heart or skipped heartbeats		
14.	Have you had high blood pressure or high cholesterol		
15.	Have you ever been told you have a heart murmur?		
16.	Has any family member or relative died of heart problems or of sudden death before age 50?		
17.	Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month		
18.	Has a physician ever denied or restricted your participation in sports for any heart problems		
19.	Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters		
20.	Have you ever had a head injury or concussion?		
21.	Have you ever been knocked out, become unconscious, or lost your memory?		
22.	Have you ever had a seizure?		
23.	Do you have frequent or sever headaches?		
24.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
25.	Have you ever had a stinger, burner, or pinched nerve?		
26.	Have you ever become ill from exercising in the heat		
27.	Do you cough, wheeze, or have trouble breathing during or after activity		
28.	Do you have asthma?		
29.	Do you have seasonal allergies that require medical treatment?		
30.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
31.	Have you had any problems with your eyes or vision?		
32.	Do you wear glasses, contacts, or protective eyewear?		
33.	Have you ever had a sprain, strain, or swelling after injury?		
34.	Have you broken or fractured any bones or dislocated any joints?		
35.	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
36.	Do you want to weigh more or less than you do now?		
37.	Do you lose weight regularly to meet weight?		
38.	Do you feel stressed out?		

39.	Record the dates of your most recent immunizations (shots) for:		
Tetanus:	Measles:	HBV:	Chickenpox:

FEMALES ONLY

40.	When was your first menstrual period?	
41.	When was your most recent menstrual period?	
42.	Do you have any current skin problems (for example period to the start of another?	
43.	How many periods have you had in the last year?	
44.	What was the longest time between periods last year?	

If you answered "yes" to any questions above, please provide explanations here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of applicant _____

Date _____

PHYSICAL EXAMINATION – ORTHOPAEDIC/PHYSICAL ASSESSMENT SCREENING

Name:		Date of Birth:
Height:	Weight:	% Body Fat (optional):
Pulse:	Blood Pressure:	Respirations:
Vision: □ WNL Uncorrected □ WNL Corrected	Pupils: □ R PEARL □ L PEARL	Posture/Scoliosis: □ Normal □ Abnormal

	WNL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee/Leg/ankle			
Foot			

Physician (print name) Physician Signature Date