Sacred Heart UNIVERSITY
ATHLETIC TRAINING

MASTER OF SCIENCE IN ATHLEITC TRAINING (MSAT) PROGRAM
VERIFICATION OF HEALTH STATUS

Student/Applicant Information (to be completed by the patient):

Student Name: _____ Date of Birth: _____

Home Address: _____

Cell phone: _____

To be completed by the Healthcare Provider (MD, DO, PA-C, APRN):

A thorough examination was performed on the above-named individual. The following assessments were included:

A. Complete medical history
B. Physical examination
C. Review of the MSAT Program Technical Standards

I have reviewed the above student's completed Sacred Heart University Health Forms and I have completed an examination and discussed the contents of this report as well as the Technical Standards of the Sacred Heart University MSAT Program with the student. Habituation to alcohol or other drugs that may alter the individual's behavior has been considered in this evaluation. Based on this, the above student:

☐ Is in good health and free from a health impairment which may pose potential risk to patients or personnel, or which may interfere with the performance of athletic training responsibilities. He/she is capable of meeting the program's Technical Standards **without** accommodation and may fully participate in the MSAT Program.

☐ May need accommodations to meet the program's Technical Standards and should seek input from the Office of Student Accessibility to determine what reasonable accommodations may be available. Please explain below or attach additional information:

_____

_____

_____

_____

_____ _____ _____

Printed Name of Healthcare Provider | Healthcare Provider Signature | Date

_____ _____

Telephone Number | Address

To the MSAT Applicant/Student:

Please read and sign below:

I acknowledge that it is my responsibility to inform the Program Director immediately, in writing, if at any time during my enrollment in the MSAT Program my health status changes in a way that may compromise my ability to meet the program's Technical Standards. I understand that any such change will be discussed with a healthcare practitioner, and that I may not be able to continue in the MSAT Program.

I understand that the clinical facilities to which I am assigned as part of my clinical education requirements for the MSAT Program may require more health data than provided in this assessment. I understand that it is my responsibility to meet all health requirements of the clinical facilities to which I am assigned.

Printed Name of Applicant/Student	Signature of Applicant/Student	Date