# Winona State University – Athletic Training Education Program
## Medical Restatement Form

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<thead>
<tr>
<th>NAME:</th>
<th>WARRIOR ID #</th>
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<tr>
<td>GENDER:</td>
<td>Male Female</td>
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<tr>
<td>DATE OF BIRTH:</td>
<td>AGE:</td>
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<td>ADDRESS:</td>
<td>PHONE:</td>
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**PHYSICIAN INSTRUCTIONS:**
As a health care provider, you are being asked to determine whether this individual may have difficulty completing the requirements for their Athletic Training clinical education. Students must possess certain abilities in order to provide safe practice. These abilities include:

A. Functional use of all sense  
B. Ability to perceive pain, pressure, temperature, position, equilibrium and movement  
C. Functional use of gross and fine motor skills to carry out assessment and care delivery, such as lifting, transferring and treatments.  
D. Ability to interact in a behaviorally appropriate manner.

Please review with the prospective student any health problems or conditions that may influence their ability to perform the above tasks in the following areas: (Please note – The WSU ATEP is NOT asking for these specific conditions to be reported on this document, only that they are addressed privately with the student during the examination.)

A. Metabolic, i.e., diabetes  
B. Neurologic, i.e., epilepsy  
C. Cardiovascular;  
D. Musculoskeletal, i.e., arthritis or low back pain;  
E. Infections/Communicable disease;  
F. Mental/Emotional stress which may affect student performance, jeopardizing the health and well being of the student or person being cared for by the student.

Upon acceptance into the Athletic Training Education Program (ATEP) at WSU, the student listed above was cleared by a health care provider on the above criteria. Since that time, the student has notified the ATEP of a health concern which may jeopardize the student and/or patient safety in the clinical setting; this condition may or may not require accommodation at this time.

Please indicate the results of your data collection:

1. ____________________________ IS/IS NOT (circle one) physically and/or emotionally able to meet the functional abilities to practice in the clinical setting.

2. The following restrictions and/or limitations would affect the student’s ability to meet each of these standards:

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Physician’s Signature: ____________________________ Date: ____________________________

Name of Physician (Print): ____________________________

Address: ____________________________

Phone: ____________________________ Fax: ____________________________