

**Southern Illinois University
Athletic Training Education Program
Athletic Training Student Physician Observation Form**

Athletic Training Student: _____ Date: _____

Patient(s) Observed: ___ Male ___ Female Location: _____

General medical condition(s): Please check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Respiratory Disorders | <input type="checkbox"/> Disorders of the Ear, Nose, Throat, & Mouth |
| <input type="checkbox"/> Cardiovascular Disorders | <input type="checkbox"/> Systemic Disorders |
| <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Infectious Diseases |
| <input type="checkbox"/> Genitourinary & Gynecological Disorders | <input type="checkbox"/> Dermatological Conditions |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Musculoskeletal Disorders |
| <input type="checkbox"/> Disorders of the Eye | <input type="checkbox"/> Mental Health Condition |

Other _____

Task observed:

- | | |
|---|---|
| <input type="checkbox"/> Initial evaluation | <input type="checkbox"/> Follow-up Evaluation |
| <input type="checkbox"/> Aspiration | <input type="checkbox"/> Suturing/Removal |

Other _____

Student Comments:

Hours Observed: _____

Physician Name: _____

Physician Signature: _____