(College Letterhead)

## STUDENT-ATHLETE

Email:_____

Student Name _____ Gender _____
(Last) (First) (Middle Initial)

Date of Birth _____ Age _____ SID _____
Month/Day/Year

Local Address _____ Phone (_____)_____
(Number & Street) (City) (Zip)

Home Address _____ Phone (_____)_____
(Number & Street) (City) (Zip)

## PARENT/GUARDIAN

Parent(s) Name _____
(Last) (First) (Middle Initial)

Home Address _____ Phone (_____)_____
(Number & Street) (City) (Zip)

## INSURANCE INFORMATION

Are you covered by group or individual health and/or accident insurance? Yes ❑ No ❑
If yes, please provide the following information:

Insurance Co. _____ Policy/Group #_____

Subscriber's Name _____ Subscriber ID#_____

## EMERGENCY CONTACTS

Name _____ Phone (_____)_____ Relationship _____

Name _____ Phone (_____)_____ Relationship _____

## FAMILY PHYSICIAN

Name _____ Phone (_____)_____

## SPORTS PROGRAM(S)

Please check ALL appropriate boxes for the sports in which you will be participating at this college:

| | | | | | |
|---|---|---|---|---|---|
| ❑ Baseball | ❑ M Basketball | ❑ M Golf | ❑ M Track | ❑ M Rodeo | ❑ M Swim |
| ❑ Softball | ❑ W Basketball | ❑ W Golf | ❑ W Track | ❑ W Rodeo | ❑ W Swim |
| ❑ Volleyball | ❑ M Cross Country | ❑ M Soccer | ❑ M Tennis | ❑ M Wrestling | ❑ Other |
| | ❑ W Cross Country | ❑ W Soccer | ❑ W Tennis | ❑ W Wrestling | _____ |

## MEDICAL CONDITIONS (e.g., medical conditions, allergies, or current medications)

_____

**PLEASE CAREFULLY AND COMPLETELY READ THE FOLLOWING INFORMATION**

Completion of this medical history and examination form is mandatory for participation in the sports programs of this college. Please make sure that all statements regarding your personal information and medical history is complete and accurate.

NWAC Regulations state: "After July 1st and prior to the first practice for participation in intercollegiate athletics, a student shall undergo a thorough medical examination and be approved for intercollegiate athletic competition by a medical authority licensed to perform a physical examination by the laws applicable in the state where the exam is conducted. Those licensed and approved to perform physical examination by the laws applicable in the state where the exam is conducted." Those licensed to perform physical examinations in the State of Washington include M.D., Doctor of Osteopathy (D.O.), Certified Registered Nurse (C.R.N.), Naturopath (N.D.) and Physician's Assistant (P.A.). The physical examination shall be valid for twenty-four (24) consecutive months to the date unless otherwise limited by the physician indicating the physical is only good for less than twenty-four (24) consecutive months.

This form is to be completed and signed by the student or, if the student is under the age of 18, by the student's parent or guardian. Any Information withheld or falsified may affect the student's status on the athletic team and/or the student's scholarship funding. The college reserves the right, with the student's authorization, to request past medical records, charts and diagnoses regarding injuries, medical history or physical condition, and may request additional medical examinations or tests if indicated.

**INFORMATION ABOUT YOUR LAST PHYSICAL EXAMINATION:**

Date _____ Doctor's name _____ City, State _____

Please list any abnormalities found on any past physical examinations _____

_____

**IMMUNIZATION RECORD**

| | | | |
|---|---|---|---|
| Measles* | ❑ Yes | ❑ No | Date of last shot _____ |
| Mumps* | ❑ Yes | ❑ No | Date of last shot _____ |
| Rubella* | ❑ Yes | ❑ No | Date of last shot _____ |
| Polio | ❑ Yes | ❑ No | Date of last dose _____ |
| Tetanus (Td) | ❑ Yes | ❑ No | Date of last shot _____ |
| COVID-19 | ❑ Yes | ❑ No | Date of last dose _____ |

*Note: These are commonly noted on immunization records as "MMR" and often given as one shot. A second dose of measles vaccine is recommended for college entrance.

**FAMILY MEDICAL HISTORY**

*Please check YES or NO in appropriate box.*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | ❑ Yes | ❑ No | Osteoporosis | 5. | ❑ Yes | ❑ No | Hemophilia |
| 2. | ❑ Yes | ❑ No | High blood pressure | 6. | ❑ Yes | ❑ No | Diabetes |
| 3. | ❑ Yes | ❑ No | Neuromuscular disease | 7. | ❑ Yes | ❑ No | Anemia |
| 4. | ❑ Yes | ❑ No | Sudden death from heart disease or stroke | 8. | ❑ Yes | ❑ No | Cancer |

*If living, please check box to signify family member's general health. If deceased, please state age and cause of death, if known.*

| | | | | | | Age at Death | Cause of Death |
|---|---|---|---|---|---|---|---|
| Father | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | | |
| Mother | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | | |
| Brother #1 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | | |
| Brother #2 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | | |
| Sister #1 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | | |
| Sister #2 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | | |

**MEDICAL CONDITIONS & ILLNESSES**

*Have you ever had or do you now have any of the following medical conditions, illnesses or diseases? Please check YES or NO for <u>EACH</u> item.*

| | YES | NO | | | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 9. | ❑ | ❑ | Polio | 26. | ❑ | ❑ | Recurrent sinusitis | 43. | ❑ | ❑ | Hernia or rupture |
| 10. | ❑ | ❑ | Diphtheria | 27. | ❑ | ❑ | Hearing loss/ear disease | 44. | ❑ | ❑ | Ulcers |
| 11. | ❑ | ❑ | Rheumatic fever | 28. | ❑ | ❑ | Rheumatic heart disease | 45. | ❑ | ❑ | Testicular masses |
| 12. | ❑ | ❑ | Hepatitis | 29. | ❑ | ❑ | Heart murmur/problems | 46. | ❑ | ❑ | Hemorrhoids |
| 13. | ❑ | ❑ | Tuberculosis | 30. | ❑ | ❑ | Pericarditis | 47. | ❑ | ❑ | Bleeding disease |
| 14. | ❑ | ❑ | Collapsed lung | 31. | ❑ | ❑ | High blood pressure | 48. | ❑ | ❑ | Anemia |
| 15. | ❑ | ❑ | Pneumonia | 32. | ❑ | ❑ | Elevated cholesterol | 49. | ❑ | ❑ | Phlebitis |
| 16. | ❑ | ❑ | Pleurisy | 33. | ❑ | ❑ | Arthritis/joint problems | 50. | ❑ | ❑ | Asthma/hay fever |
| 17. | ❑ | ❑ | Diabetes | 34. | ❑ | ❑ | Bone infection | 51. | ❑ | ❑ | Skin disease/rash |
| 18. | ❑ | ❑ | Allergies | 35. | ❑ | ❑ | Chondromalacia | 52. | ❑ | ❑ | Measles |
| 19. | ❑ | ❑ | Tumors/Cancer | 36. | ❑ | ❑ | Seizures/Epilepsy | 53. | ❑ | ❑ | Mumps |
| 20. | ❑ | ❑ | Muscular disease | 37. | ❑ | ❑ | Migraine headaches | 54. | ❑ | ❑ | Mononucleosis |
| 21. | ❑ | ❑ | Eye disease | 38. | ❑ | ❑ | Neurological disorder | 55. | ❑ | ❑ | Malaria |
| 22. | ❑ | ❑ | Color blindness | 39. | ❑ | ❑ | Goiter/thyroid disease | 56. | ❑ | ❑ | Car or air sickness |
| 23. | ❑ | ❑ | Near sightedness | 40. | ❑ | ❑ | Enlarged organs (spleen) | 57. | ❑ | ❑ | Nervous breakdown |
| 24. | ❑ | ❑ | Far sightedness | 41. | ❑ | ❑ | Kidney or bladder disease | 58. | ❑ | ❑ | Mental disorder |
| 25. | ❑ | ❑ | Nasal polyps | 42. | ❑ | ❑ | Gastrointestinal bleeding | 59. | ❑ | ❑ | Eating disorder |



## INJURIES & SYMPTOMS

*Do currently have or have you ever had any of the following symptoms, problems or injuries?*
*Please check YES or NO for <u>EACH</u> item.*

| | YES | NO | | | YES | NO | | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 60. | ❑ | ❑ | Frequent headache | 71. | ❑ | ❑ | Neck pain or injury | 82. | ❑ | ❑ | Muscle weakness |
| 61. | ❑ | ❑ | Head injury | 72. | ❑ | ❑ | Back pain or injury | 83. | ❑ | ❑ | Muscle cramps |
| 62. | ❑ | ❑ | Visual changes | 73. | ❑ | ❑ | Knee pain or injury | 84. | ❑ | ❑ | Muscle wasting |
| 63. | ❑ | ❑ | Eye pain or injury | 74. | ❑ | ❑ | Ankle pain or injury | 85. | ❑ | ❑ | Frequent nausea |
| 64. | ❑ | ❑ | Ringing in ears | 75. | ❑ | ❑ | Shoulder dislocation/sep. | 86. | ❑ | ❑ | Frequent vomiting |
| 65. | ❑ | ❑ | Sore throats | 76. | ❑ | ❑ | Other joint sprain/disloc. | 87. | ❑ | ❑ | Frequent diarrhea |
| 66. | ❑ | ❑ | Nasal fracture | 77. | ❑ | ❑ | Joint pain, at rest | 88. | ❑ | ❑ | Abdominal problems |
| 67. | ❑ | ❑ | Sinus congestion | 78. | ❑ | ❑ | Joint pain, with exercise | 89. | ❑ | ❑ | Internal injuries |
| 68. | ❑ | ❑ | Breathing difficulty | 79. | ❑ | ❑ | Joint weakness | 90. | ❑ | ❑ | Rectal bleeding |
| 69. | ❑ | ❑ | Recurrent coughing | 80. | ❑ | ❑ | Pinched nerve | 91. | ❑ | ❑ | Unusual fatigue |
| 70. | ❑ | ❑ | Chest pain | 81. | ❑ | ❑ | Heat exhaustion/stoke | 92. | ❑ | ❑ | Trouble sleeping |

## GENERAL QUESTIONS

*Please answer ALL of the following questions by checking either YES or NO for <u>EACH</u> item.*

| | YES | NO | |
|---|---|---|---|
| 93. | ❑ | ❑ | Do you now have or have you ever had any chronic or recurrent illnesses? |
| 94. | ❑ | ❑ | Have you ever had any illnesses lasting more than one week? |
| 95. | ❑ | ❑ | If no to #93 or #94, do you now have or have you ever had any illnesses requiring treatment and care of a doctor? |
| 96. | ❑ | ❑ | Do you wear eyeglasses or contact lenses? |
| 97. | ❑ | ❑ | Do you currently wear eyeglasses or contact lenses while participating in sports? |
| 98. | ❑ | ❑ | Do you use any dental appliances such as braces, bridges or plates? |
| 99. | ❑ | ❑ | Any body parts or organs missing (appendix, eye, kidney, testicles)? |
| 100. | ❑ | ❑ | Are you now or have you ever been under the treatment of a medical doctor for any injuries? |
| 101. | ❑ | ❑ | Have you ever fainted, passed out, been dizzy, knocked out, unconscious or had a concussion? |
| 102. | ❑ | ❑ | Have you ever had a cast, splint, cane or crutches? |
| 103. | ❑ | ❑ | Have you ever had an X-ray of any bone or joint? |
| 104. | ❑ | ❑ | Do you have to stop while running twice around a quarter-mile track? |
| 105. | ❑ | ❑ | Do you have any trouble breathing, while at rest, <u>after</u> running one mile? |
| 106. | ❑ | ❑ | Do you get any chest pain with exercise? |
| 107. | ❑ | ❑ | Have you ever had any injuries or illnesses that caused you to miss a game or practice? |
| 108. | ❑ | ❑ | Are there any reasons why you should not participate in sports? |
| 109. | ❑ | ❑ | Have any of your close relatives, under the age of 50, died of heart problems or unexplained causes? |
| 110. | ❑ | ❑ | Are you or any member of your family allergic to ANY medications (aspirin, penicillin, etc.)? |
| 111. | ❑ | ❑ | Are you now taking or have you taken any medications, medicines, drugs or vitamins on a regular basis? |
| 112. | ❑ | ❑ | Do you have any medical conditions that require special attention or treatment that the coach or athletic trainer should be aware of in the event of any injury or illness? |

*If you have answered "**Yes**" to any numbered item (1-112), please explain the situation or circumstances, including names of treating physicians and dates in the space provided. Identify each response by the number of the item in the left margin.*

| Item No. | Physician, City, State | Approx. Date | Explanation, including any surgeries you have had |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Student Name _____
(Last) (First) (Middle Initial)

***Please list all previous fractures, concussions or other head injuries:***

| Item No. | Physician, City, State | Approx. Date | Injury |
|---|---|---|---|
| | | | |
| | | | |

***Please list all hospitalizations:***

| Item No. | Physician, City, State | Approx. Date | Reason for hospitalization, length of stay |
|---|---|---|---|
| | | | |
| | | | |

***Describe your current pattern of physical exercise***

| Activity | Frequency | Duration | Intensity |
|---|---|---|---|
| | | | |
| | | | |

Describe the sickest you have ever been _____

_____

Describe any weight changes over the last six months_____

List *all* medications -- prescription and/or over the counter -- drugs or vitamins that you currently take (including aspirin, birth control pills, etc.) _____

_____

Describe any allergies -- from bites, drugs, foods, pollen, etc. -- you may have, including causes and reactions _____

_____

At what age did you have your first menstrual period? _____ How many have you had during the last 12 months? _____

Date of last period _____ Describe any menstrual irregularity or discomfort _____

## AGREEMENT OF UNDERSTANDING

I, the undersigned, certify that the above medical history is correct and true to the best of my knowledge, and that this student has no physical defects except as stated. This medical information is given with my permission and the medical examination is taken voluntarily. I further understand that any intentional omission of answers either verbally or in writing may result in disqualification from the community college sports program.

I authorize the release of this medical information, including the medical examination and the results of any medical tests, to the college for their use, evaluation and record keeping for this student-athlete's participation in the sports program of the college. I further authorize the release of this medical information, the medical examination and the results of any medical tests when deemed necessary by the college athletic coach, athletic trainer or other authorized college official; and I grant permission to any hospital, physician, surgeon, or other duly authorized medical personnel to release any other medical records, charts or diagnoses when deemed necessary for the treatment and care of this student-athlete in the event of injury or illness.

I further authorize and request the college's designated medical personnel to administer basic life support, advanced life support, and/or to obtain emergency medical care in the event of injury or illness at any specific emergency care facility so designated by the college physician or representative while participating in the sports program.

By my signature I verify that I have read, understand and agree to the above-stated conditions.

Student _____ Date _____

Parent/Guardian (If student is under 18 years of age)_____

Student Name _____
(Last) (First) (Mid. Initial)

# PHYSICAL EXAMINATION FOR SPORTS PARTICIPATION

To be completed by Licensed Medical Provider

To the Medical Provider: Please obtain and review the student's health history, pages one through four of this form, before conducting the examination. The intent of this exam is to focus on conditions of the athlete that may endanger his/her health, aggravate pre-existing conditions or increase the risk of death from participation in competitive college sports. If your findings or observations during this exam for sports participation indicate a need for a more comprehensive medical examination, you have the option of conducting a more comprehensive exam or advising the athletic director of the college in writing of the need for same. We appreciate your assistance and cooperation in maintaining the health of our student-athletes.

Student Name _____
(Last) (First) (Middle Initial)

Date of Birth _____ Male ❑ Female ❑ Height _____ Weight _____
Month/Day/Year

Blood pressure at rest and sitting: Left arm _____/_____ mmHG Right arm _____/_____ mmHG

Resting pulse rate: Apical _____ Radial _____

Visual acuity: Left 20/_____ Right 20/_____ Please check appropriate box: ❑ With correction ❑ Without correction

***Please check appropriate box to indicate if Normal or Abnormal, and provide comments if abnormal.***

| SYSTEM | | N | AB | COMMENTS |
|---|---|---|---|---|
| HEAD | Hair, scalp, masses, injuries | | | |
| EYES | Proptosis, conjunctivae, sclera, EOM, pupillary size, reaction to light, peripheral vision, fundi, gross tension to palpation | | | |
| EARS | Gross hearing to speech, drums, discharges | | | |
| NOSE | Septum, mucosa, sinuses | | | |
| THROAT/MOUTH | Teeth, tongue, tonsils, infections, lesions | | | |
| NECK | Thyroid, vessels, range of motion, adenopathy, masses, voice abnormalities | | | |
| THORAX/LUNGS | Shape, expansion, deformities, rhonchi, wheezes, rales | | | |
| HEART | PMI, sounds, thrills, murmurs, gallops, PVCs | | | |
| LYMPHATICS | Cervical, axillary | | | |
| ABDOMEN | Organ enlargement (liver, spleen, etc.), masses, tenderness, hernias, scars | | | |
| GENITALIA | Scrotum, testicles, lesions, discharge, hernias | | | |
| RECTAL (Optional) | Hemorrhoids, fissures, prostate, masses | | | |
| UPPER EXTREMITIES | Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries | | | |
| LOWER EXTREMITIES | Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries | | | |
| BACK | Flexion, extension, scoliosis, kyphosis, excessive lordosis, injuries | | | |
| NEUROLOGICAL | Cranial nerves, reflexes, motor, gait, balance, sensory | | | |
| SKIN | Texture, striae, rash, acne | | | |
| MENTAL STATUS | Affect, hostility, agitation, depression, anxiety | | | |
| COVID-19 History | History of prior infection | ☐ No | ☐ Yes | |
| Do you recommend further COVID-19 or follow up testing after moderate or severe infection? (Cardiology consult or Respiratory Consult) | | ☐ No | ☐ Yes | |
| Is this individual at high risk for complications if no prior history of infection? | | ☐ No | ☐ Yes | |
| *If yes, were they counseled about their risks of participation in a high-risk activity?* | | ☐ No | ☐ Yes | |

## LABORATORY TESTS (Optional or as indicated by examination)

Urinalysis: Sugar _____ Albumin _____ Ketones _____ Other _____

Hematology: Hematocrit _____

Summary of abnormal lab work _____

***If medical history indicates the need for any vaccinations or booster shots, please administer during the physical examination.***

Orthopedic Diagnoses _____

_____

General Medical Diagnoses _____

_____

_____

_____

Additional findings or comments on health history/significant injuries or illnesses _____

_____

## DISPOSITION **(Please check one)**

- ❑ Unrestricted activity in all sports
- ❑ No participation until _____ or until _____
  (Date) (Conditions to be met)
- ❑ May participate, but with following limitations _____
- ❑ May not participate at all for following reasons _____

Medical Provider's signature _____ Date of Exam _____

## MEDICAL PROVIDER IDENTIFICATION (Please print. Stamp or label okay)

Name _____ Phone (_____) _____

Address _____ City _____ Zip _____

Mail completed form to: (COLLEGE)

**NOTE**: The original of this report shall be confidentially filed and maintained in the athletic department. The information shall be readily available to health care providers in event of an emergency when intercollegiate sports are conducted, both at home and away from the college.

Student Name _____
(Last) (First) (Mid. Initial