

# New or Transfer Student-Athletes and Parents (Athletes – Please keep this page for information)

The following information is extremely important for athletic preparation and eligibility at Community Colleges of Spokane (CCS). The primary concern of the Athletic Training Staff and team physicians is to provide medical care for student-athletes at CCS. Please read these instructions, complete the appropriate forms, and mail all documents needed to the address below. If you have questions, please contact the HEAD COACH for your sport.

In the required packet, you will find the following forms and requests for associated documents:

## 1. NWAC Athletic Questionnaire/Recruiting Disclaimer

This form contains all required NWAC and CCS required eligibility information. This form must be fully completed, signed and dated.

## 2. Health History

Community Colleges of Spokane's Athletic Department Policy states that all student-athletes must pass a pre-participation physical examination **after July 1<sup>st</sup> and prior to participation** in intercollegiate athletics. This initial examination must be obtained and all documentation must be turned in prior to any athletic participation. If you are currently experiencing a medical problem or have had any major illness or significant injury in the past twelve months you MUST provide a written release authorizing your participation in varsity intercollegiate athletic from your treating licensed health care provider. You will not be eligible for participation until this written release is received. If necessary, you may send this release separately.

## 3. Insurance Information

Community Colleges of Spokane provides secondary insurance coverage for all student athletes which is in effect during officially scheduled and supervised participation in varsity athletics. Summit America Insurance administers this excess athletic policy which is designed to pay the balance of covered expenses up to the maximum of the policy after the bills have been processed through the student's primary insurance. For these purposes, the primary insurance is your personal insurance which may be coverage through a parental policy. The CCS Athletic Department is intended to pay any deductibles the primary insurance or athletic insurance does not pay. Any student-athlete who sustains an injury that occurred during supervised participation (when a coach is present) during the season is covered under this secondary policy, up to the policy limits and under its restrictions. The primary insurance will be billed first and student-athletes and/or their parents/guardians if under age 18 are responsible for providing the remaining statement balance to the insurance coordinator for processing payment. Information on the athletic insurance policy is available upon request of the athletic trainer.

**\*\*\* In order to provide the proof of primary insurance you must attach a COPY of your insurance card(s) \*\*\*  
front and back to the insurance form submitted to Community Colleges of Spokane.**

## 4. Student-Athlete Authorization for Release of Protected Health Information

The Athletic Training Staff may refer student-athletes to medical specialists if deemed appropriate based on a particular medical issue or injury. In this circumstance, an authorization is necessary for the Athletic Training Staff to provide protected health information to the medical specialist. The Student Consent for Release of Protected Health Information form provides this authorization and is valid for 380 days from the date of your signature.

## 5. FERPA Consent Form

FERPA restricts the disclosure of educational records. This form provides consent for college officials to share educational records orally or in writing in order for student athlete to maintain athletic eligibility. This form must be signed and dated to authorize such disclosures.

**ALL FORMS MUST BE SUBMITTED PRIOR TO THE FIRST PRACTICE OF THE YEAR!**

Return all forms to **SFCC** if you are competing in any of the following sports:

- Baseball
- Basketball-Women
- Soccer - Men
- Softball
- Volleyball

[Nancy.Zacher@ccs.spokane.edu](mailto:Nancy.Zacher@ccs.spokane.edu) ■ 509 533-3630

Spokane Falls Community College \* MS 3070  
3410 W Fort George Wright Drive  
Spokane, WA 99224-5288

Return all forms to **SCC** if you are competing in any of the following sports:

- Basketball-Men
- X-Country-M/W
- Golf-M/W
- Soccer-Women
- Tennis-M/W
- Track & Field-M/W

[Wendy.Irish@ccs.spokane.edu](mailto:Wendy.Irish@ccs.spokane.edu) ■ 509 533-7230

Spokane Community College \* MS 2050  
1810 N Greene Street  
Spokane, WA 99217-5399



## Northwest Athletic Conference ATHLETIC QUESTIONNAIRE

This form **MUST** be completed and returned to your coach or the college Athletic Office before participating in ANY athletic activity is permitted. All information **MUST BE COMPLETED. FRONT AND BACK. PLEASE PRINT CLEARLY.**

COLLEGE ATTENDING	<input type="checkbox"/> SCC	<input type="checkbox"/> SFCC	<input type="checkbox"/> BOTH	SPORT(S)	SCHOOL YEAR
FULL NAME					<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STUDENT ID #					BIRTHDATE
LOCAL ADDRESS					
CITY, STATE, ZIP					
PERMANENT ADDRESS (if different from above)					
CITY, STATE, ZIP					
CELL PHONE			EMAIL		
HIGH SCHOOL		CITY, STATE			GRADUATION DATE

If you did not attend college immediately following high school, identify activities you were involved in during that time period:		
DATES	ACTIVITIES	
If you have attended other collegiate institutions (including community college) since high school (this includes any previous years at CCS), complete the following:		
DATES ATTENDED (MONTH & YEAR)	COLLEGE	CITY/STATE
If a transfer student, number of hours transferred:		
	Quarter Hours	Semester Hours
Are official transcripts from all previous colleges on file with the admissions office at SCC or SFCC? <span style="float: right;"><input type="checkbox"/> YES    <input type="checkbox"/> NO</span>		

<b>ATHLETIC PARTICIPATION</b>	
Have you participated in an intercollegiate CONTEST/EVENT since high school?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you participated in an intercollegiate PRACTICE since high school?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, list any participation at all colleges attended, including the present college (i.e., CCS):	
DATES	PARTICIPATION
Are you currently participating on another team? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, name the team
When was the last time you participated?	Have you notified the team you are leaving? <input type="checkbox"/> YES <input type="checkbox"/> NO

<b>LETTER OF INTENT</b>		
Have you ever signed a Letter of Intent? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, for what sport?	
College	City/State	Year:

<b>AMATEURISM</b>	
Have you participated on or tried out for a professional team?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever played with, received payment from, or signed a contract to play with a professional team?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, list sport, organization, and date signed:	

SCHOLARSHIPS AND FINANCIAL STATUS		
Have you been awarded an athletic tuition grant-in-aid at this college for this academic year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you received any other (non-athletic) scholarship and/or aid from this college for this academic year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

ALL ACADEMIC TEAM AND ACADEMIC LEADERSHIP AWARD	
College Major:	Educational Goal:
List sport(s) and year(s) participated in high school:	
List athletic and academic honors and awards received in high school:	
List athletic and academic honors and awards received in college:	

ATTENDANCE VERIFICATION	
Are you attending CCS because of the athletic program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Since your decision to attend, have any friends/relatives also chosen to attend?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please list their names:	1. _____ 4. _____
	2. _____ 5. _____
	3. _____ 6. _____
List your estimated monthly expenses for Food \$ _____ Lodging \$ _____	If you live with parent(s) and do not pay, list \$0.00.

**NWAC RECRUITING DISCLAIMER**

In accordance with the NWAC Code Book (Article VI, Section 2), athletic recruiting is only allowed in the states of **Washington, Idaho, Oregon, Montana, Alaska, Hawaii, California, Nevada, Utah or Wyoming and the province of British Columbia**. Student-athletes whose home residence is outside the aforementioned contiguous states must submit an NWAC Athletic Questionnaire and Recruiting Disclaimer to the conference office. Passed 6/15/15; Effective 7/1/15

*To the best of my knowledge, the information I have provided is accurate and complete. I understand that falsification of my academic or athletic participation records will result in immediate suspension of athletic eligibility in any sport at any NWAC member college.*

*I give my permission for the Athletic Department to use my student Identification number for eligibility purposes, including use on forms and transcripts, as required when sent to other schools and to the NWAC office.*

STUDENT-ATHLETE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NWAC, PLS 033  
 Clark College  
 1933 Fort Vancouver Way  
 Vancouver, WA 98663



### MEDICAL HISTORY & PRE-PARTICIPATION EXAM FORM

This form **MUST** be filled out and returned to your coach or the college Athletic Office before participation in ANY athletic activity is permitted.  
All information **MUST BE COMPLETED. PLEASE PRINT CLEARLY.**

### **TO BE COMPLETED BY FIRST-YEAR OR NEW ATHLETES ONLY**

FULL NAME (PRINT) \_\_\_\_\_

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ATTENDING  SCC  SFCC  BOTH      SID # 

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SCHOOL YEAR \_\_\_\_\_ E-MAIL \_\_\_\_\_

MALE  FEMALE      BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

MONTH/DAY/YEAR

SPORT(S) \_\_\_\_\_  FRESHMAN  SOPHOMORE

LOCAL ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PERMANENT ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

### **THIS INFORMATION WILL BE KEPT CONFIDENTIAL**

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 are complete and accurate.

NWAC Regulations state: After July 1<sup>st</sup> and prior to the first practice of each year of participation in intercollegiate athletics a member college, a student-athlete shall undergo a 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 examinations include; Medical Doctors (M.D.), Doctors of Osteopathy (D.O.), Certified Registered Nurses (C.R.N.), Naturopaths (N.D.) and Physician's Assistants (P.A.).

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.

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**A. FAMILY MEDICAL HISTORY:**

Has any close blood relative ever had any of the following conditions? If **YES**, please provide who and when.

	Use this column to briefly explain YES answers		
1. Cardiovascular Disease		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Heart Attack		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Died suddenly before age 50 years		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Neuromuscular Disease		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Diabetes		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. High Blood Pressure		<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Sickle Cell Trait/Anemia		<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Marfan Syndrome		<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Stroke		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**B. GENERAL MEDICAL HISTORY:**

Have you ever had or do you now have any of the conditions below? If **YES**, please provide applicable dates regarding the condition.

	Use this column to briefly explain YES answers		
1. Do you have or have you ever been treated for <u>diabetes</u> ? If <b>YES</b> , please list the age at which your diabetes began as well as all medications you take for this condition.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Do you have or have you ever had an <u>epileptic seizure</u> ? If <b>YES</b> , when?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you ever suffered from or been diagnosed with <u>Asthma</u> or <u>Exercise Induced Asthma</u> ? If <b>YES</b> , what medication are you taking to control it?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Do you have any <u>heart disease, disorder or murmur</u> ? If <b>YES</b> , describe and list any medication you are taking.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever been tested for a heart condition? If so, please list the test. (EKG, echocardiogram, stress test)		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Do you have <u>Sickle Cell Trait/Anemia</u> ?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. During the last 12 months have you had any type of problem with intolerance to exercise?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Have you ever passed out before, during or after exertional activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Have you ever had trouble with dehydration, heat intolerance, heat cramps, heat exhaustion or heat stroke?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Have you ever had an injury to an internal organ?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Have you ever lost full use of any organ, either temporarily or permanently? (Eyes, Ears, Kidneys, Lungs, etc.)		<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. In the past 24 months have you been treated for the following?			
Mononucleosis		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pneumonia		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tuberculosis		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Infectious Virus		<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Do you have a vision defect in either one or both eyes?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
14. DO you wear glasses during activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
15. Do you wear contacts during activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. Do you wear dental appliances?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you wear them during activity?	<input type="checkbox"/> YES <input type="checkbox"/> NO
17. Have you had a tetanus shot in the last 3 years?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
18. Have you ever received the Hepatitis B (HBV) Vaccination?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
19. Any other medical conditions?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

FULL NAME (PRINT) \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ SID# \_\_\_\_\_

**C. ALLERGIES:** Are you allergic to any of the following items?

Aspirin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Penicillin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Acetaminophen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bee Stings	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Codeine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Erythromycin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Novocain or other anesthetics	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Iodine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sulfa Drugs	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ibuprofen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tetnus antitoxin or serums	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Latex	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If <b>YES</b> , please list those allergies here:										<input type="checkbox"/> YES	<input type="checkbox"/> NO

**D. GYNECOLOGICAL HISTORY: \*\*\*ONLY FEMALES ANSWER THIS SECTION\*\*\***

IN THE PAST 12 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING?

		Years				Years				Years	
Absence of Menstruation	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Menstrual Cramps	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Scanty Flow	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Painful Menstruation	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Irregular Periods	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Excessive Flow	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Are currently taking Birth Control Pills?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	If <b>YES</b> , what type are you taking?						

**E. EATING DISORDERS:**

<b>Use this column to briefly explain YES answers</b>		
1. Diagnosis of anorexia? If <b>YES</b> , when and where?		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Diagnosis of bulimia? If <b>YES</b> , when and where?		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. A problem with food bingeing?		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Do you sometimes or often induce vomiting after eating?		<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Taken laxatives to lose weight?		<input type="checkbox"/> YES <input type="checkbox"/> NO

**F. CONCUSSIONS:**

1. Have you ever had a <u>concussion</u> ? If <b>YES</b> , please list the dates and how long the symptoms lasted for each.		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever been hospitalized for any of the concussions you sustained? If <b>YES</b> , please list the dates.		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you ever been knocked unconscious? If <b>YES</b> , please list the dates.		<input type="checkbox"/> YES <input type="checkbox"/> NO

**G. CURRENT MEDICATIONS:**

1. Are you currently taking any prescription medications? Including supplements and vitamins.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If <b>YES</b> , please list all with <b>DOSAGE</b> information and <b>EXPLAIN</b> purpose:		

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**ORTHOPEDIC MEDICAL HISTORY:**

For YES answers check which side if applicable and list when the injury occurred and what the injury was/is.

Please be brief in your explanation as space is limited.

**H. HEAD:**

	Use this column to briefly explain YES answers		
1. Do you have frequent headaches or migraines? If YES, do you take medication? What medication?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**I. SPINE:**

1. Have you ever injured your lower back or suffered from chronic low back pain?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Were you ever diagnosed with a spinal defect of any type?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you ever had back surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**J. NECK:**

1. Have you ever sustained a serious neck or cervical injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Did you have numbness, burning, or sharp pain in your arms or legs?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you ever had an injury producing weakness or numbness of your arms or legs or both?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Were you ever transported by ambulance for a neck injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever had neck surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have you ever had a burner or stinger (stretched or pinched nerve)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Do you currently have any weakness due to a neck or spinal injury? If YES, give the location(s) of the weakness.		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**K. SHOULDER:**

1. Have you ever suffered a significant shoulder injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
2. Has your shoulder ever felt like it was unstable or slipping?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
3. Have you ever had a problem with your shoulder repeatedly coming out of place?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
4. Do you have any problems with your shoulder during overhead activities?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
5. Have you ever had shoulder surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**L. ELBOW, WRIST, HAND, FINGER:**

1. Have you ever had an elbow injury or problem?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
2. Have you ever had a wrist injury or problem?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
3. Have you ever had a hand or finger injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
4. Do you have a finger deformity as a result of an injury? If YES, which finger?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
5. Have you ever had elbow, wrist, hand or finger surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**M. HIP:**

1. Have you ever injured either hip?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
2. Have you ever had hip surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

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**N. KNEES:**

		Use this column to briefly explain YES answers			
1. Have you ever had a knee injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
2. Did you have surgery for you knee injury(s)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
<b>If you have had a significant knee injury or knee surgery, answer the following questions:</b>					
Were you placed on a rehabilitation program?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Do you wear any type of preventative/protective brace when you practice or play?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
3. Does your knee ever swell or collect fluid?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
4. Have you ever suffered from patellar tendinitis or jumper's knee?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
5. Have you ever been diagnosed with Osgood-Schlatter's disease?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**O. ANKLES:**

1. Have you ever sustained an ankle injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
2. Have you ever had surgery on your ankle(s)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**P. FEET AND TOES:**

1. Have you ever had a foot or toe injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
2. Have you ever had a problem with bunions?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**Q. MUSCLE INJURIES:**

1. Have you ever had a severe muscle pull or strain? <b>What muscle(s) and when?</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Has this injury reoccurred? <b>If YES, list the muscle(s) involved and date(s).</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**R. OTHER SUGERY:**

If you have ever had any **other** surgeries not listed above; please list them below:

DATE	SURGICAL PROCEDURES	LOCATION	COMPLICATIONS?

**S. OTHER:**

If you have any additional conditions, problems, or comments that have not been addressed in the above questionnaire, please use the space below or attach additional sheets to inform us so that we may be able to better serve you with our best medical care.



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**Certification of Accuracy:**

By signing below, I certify that all statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur while participating in athletics at Community Colleges of Spokane. I further understand that any intentional omission of answers either verbally or in writing may result in disqualification from the community college sports program.

**Authorization to Release Medical Information:**

I authorize the release of this medical information 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 when deemed necessary by the college athletic coach, Certified Athletic Trainer or other authorized college official for the purposes of determining my fitness to participate in athletics and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur while participating in athletics at Community Colleges of Spokane.

I authorize any hospital, physician, surgeon, or other duly licensed health care provider to release any medical records, charts or diagnoses related to the treatment and care of this student athlete to Community Colleges of Spokane in the event of any injury or illness which relates to student athlete's eligibility or ability to participate in athletics or any injury or illness which the student athlete may incur while participating in athletics, including training, conditioning, practices, games, and athletic related events. This authorization expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance to this authorization.

**Consent to Medical Care:**

I 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 Certified Athletic Trainer 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-ATHLETE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE (IF UNDER 18) \_\_\_\_\_ DATE \_\_\_\_\_

# PHYSICAL EXAMINATION FOR SPORTS PARTICIPATION

To be completed by Licensed Medical Provider (MD, DO, APN, or PA) ONLY

To Medical Provider: Please obtain and review the student-athlete's health history, pages one through six 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 preexisting 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 Certified Athletic Trainer 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 MI

BIRTHDATE \_\_\_\_\_  MALE  FEMALE HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

BLOOD PRESSURE  LEFT  RIGHT \_\_\_\_\_ / \_\_\_\_\_ mmHG

RESTING PULSE \_\_\_\_\_

VISUAL ACUITY LEFT 20/ \_\_\_\_\_ RIGHT 20/ \_\_\_\_\_  WITH CORRECTION  WITHOUT CORRECTION

INDICATORS	NORMAL	ABNORMAL FINDINGS/COMMENTS			
General Appearance	YES				
Head	YES				
Eyes/Sclera/Pupils	YES				
Ears	YES				
Gross Hearing	YES				
Nose/Mouth/Throat	YES				
Lymph Glands	YES				
Cardiovascular	YES				
Heart Rate	YES				
Rhythm	YES				
Murmur	ABSENT				
If murmur present		Standing makes it:	Louder	Softer	No Change
		Squatting makes it:	Louder	Softer	No Change
		Valsalva makes it:	Louder	Softer	No Change
Femoral Pulses	YES				
Lungs: Auscultation/Percussion	YES				
Chest Contour	YES				
Skin	YES				
Abdomen (live, spleen, masses)	YES				
Assessment of physical maturation or Tanner Scale	YES				
Testicular Exam (Males ONLY)	YES				
Neck/Back/Spine	YES				
Range of Motion	YES				
Scoliosis	ABSENT				
Upper Extremities: ROM, Strength, Stability	YES				
Lower Extremities: ROM, Strength, Stability	YES				
Neurological: Balance & Coordination	YES				
Hernia	ABSENT				
Evidence of Marfan Syndrome	ABSENT				

FULL NAME (PRINT) \_\_\_\_\_  
LAST FIRST MI

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

GENERAL MEDICAL DIAGNOSIS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ORTHOPEDIC DIAGNOSES \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADDITIONAL FINDINGS OR COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DISPOSITION (PLEASE CHECK ONE)**

- Unrestricted activity in all sports
- No participation until \_\_\_\_\_ or until \_\_\_\_\_  
DATE CONDITIONS TO BE MET
- May participation, but with following limitations \_\_\_\_\_
- May NOT participate at all for following reasons \_\_\_\_\_

MEDICAL PROVIDERS SIGNATURE \_\_\_\_\_

LICENSE TYPE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL PROVIDER IDENTIFICATION (PLEASE PRINT. STAMP OR LABEL OKAY)**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_







## FERPA CONSENT FORM

I understand that in order to remain eligible to participate in intercollegiate athletics my academic progress will be monitored by my coaches, counselors and my parents and/or guardians.

I also understand that the potential to be recruited to continue athletic competition at another institution will involve the sharing of information with recruiters, coaches and other college officials outside of this institution.

To these ends, I give my written consent for school officials, including college faculty, administration, staff, and student workers at the Community Colleges of Spokane to share my educational records, in oral or written form, with the above listed parties.

FULL NAME (PRINT) \_\_\_\_\_ SID# \_\_\_\_\_

STUDENT-ATHLETE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SPORT(S) \_\_\_\_\_