PART I: MEDICAL HISTORY OF STUDENT-ATHLETE FOR PARTICIPATION IN INTERCOLLEGIATE ATHLETICS AT CCBC CATONSVILLE, DUNDALK AND ESSEX

To be completed by student-athlete, OR PARENT/GUARDIAN IF UNDER 18 YEARS OF AGE and submitted to the examining physician BEFORE the pre-participation physical examination.

Student Athlete: ____

Last　　First　　Middle

____

Home Address　　City　　Zip

__________　　__________　　__________

Date of Birth　　Home phone　　Sport

PERSONAL HEALTH AND MEDICAL HISTORY OF STUDENT-ATHLETE:

Please provide further explanation if you answer "YES" to any of the questions.

1. Do you have an ongoing or chronic illness? **Y / N**
   If yes, please explain: ______________________________
2. Have you ever been hospitalized overnight? **Y / N**
   If yes, please explain when and what for: ______________________________
3. Have you ever had a surgery? If yes, which body part: (indicate left or right if applicable)
   ______________________________ **Y / N**
4. Are you currently taking any prescription or over-the-counter medications? **Y / N**
   If yes, please explain: ______________________________ **Y / N**
5. Have you ever taken any supplements, vitamins or herbs to help you gain or lose weight or improve your performance? If yes, please explain: ______________________________ **Y / N**
6. Have you ever passed out or felt dizzy during or after exercise? **Y / N**
7. Have you ever experienced chest pain during or after exercise? **Y / N**
   If yes, have you had a cardio exam? ______________________________
8. Do you get tired more quickly than your friends during exercise? **Y / N**
9. Have you ever felt your heart racing or skipped a beat? **Y / N**
10. Have you or any direct family member had high blood pressure or high cholesterol? **Y / N**
11. Have you ever been told that you have a heart murmur? **Y / N**
12. Has any family member died of heart problems or of sudden death before age 45? **Y / N**
    If yes, from what and what relations to you?______________________________
13. Has a physician ever denied or restricted your participation in sports for any heart problem? **Y/ N**
    If yes, please explain: ______________________________
14. Have you had a severe viral infection (e.g. mononucleosis) within the last month? **Y / N**
    If yes, please explain: ______________________________
15. Do you have any current skin problems (e.g. acne, itching, rashes, warts, fungus or blisters)? **Y / N**
    If yes, please explain: ______________________________
16. Have you ever had a head injury or concussion? **Y / N**
    If yes, when and number of times: ______________________________

17. Have you ever been knocked out, become unconscious or lost your memory? **Y / N**
    If yes, when and number of times: ____
18. Have you or any direct family member ever had a seizure? **Y / N**
19. Do you have frequent or severe headaches? **Y / N**
20. Have you had numbness or tingling in arms, hands, legs or feet? **Y / N**
    If yes, please explain: ____
21. Have you ever had a "stinger", "burner" or a pinched nerve? **Y / N**
22. Have you ever become ill from exercising in the heat? **Y / N**
    If yes, when and were you hospitalized? ____
23. Do you have severe coughing, wheezing or difficulty breathing during or after activity? **Y / N**
24. Do you have asthma? **Y / N**
    If yes, are you medicated and/or use an inhaler? _________________________________
    * Please provide a spare inhaler to your athletic trainer for emergency situations.
25. Do you have any allergies? (e.g. pollen, medicine, food, or stinging insects?) **Y / N**
26. Have you had any problems with your eyes or vision? **Y / N**
27. Do you wear glasses, contacts or protective eyewear? **Y / N**
28. Do you want to weigh more or less than you do now? **Y / N**
29. Do you feel stressed out? **Y / N**
30. Female only:
    When was your first menstrual period? _____________________________________
    When was your most recent menstrual period? ______________________________
    Do you have severe cramp or irregular flow? _______________________________
31. Dates of your most recent immunizations (shots)
    Tetanus___________, MMR ___________, Hepatitis B___________, Chickenpox___________
32. Do you use any special protective or corrective equipment (e.g. knee brace, orthotics or hearing aids)? **Y / N**
33. Do you have any pins, plates, screws or anything metal in your body? **Y / N**
34. Have you ever had a sprain, strain or swelling after injury? **Y / N**
35. Have you ever broken or fractured any bone or dislocated any joint? **Y / N**
36. Do you have other illnesses or orthopedic problems which require medical attention or that your athletic trainer should be aware of? **Y / N**
    If yes, please explain: ____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I give my permission to the physician to complete PART II for confidential use in meeting my health for sports participation and educational needs in school.

____
Signature of Student-Athlete (or Parent/Guardian, if Athlete is Under Age of 18) Date

PART II: PRE-PARTICIPATION MEDICAL EXAMINATION
FOR STUDENT-ATHLETE OF CCBC CATONSVILLE, DUNDALK AND ESSEX

To be completed by Licensed Physician, Physician Assistant and/or Nurse Practitioner practicing under a Licensed Physician.

Student Athlete: ____
Last First Middle

Age: ___________ Gender: ________________

Significant Illness / Injury: ____

PHYSICIAN'S EXAMINATION:
(Check abnormal findings and explain below)

Height _______ Weight ________lbs Blood Pressure _____/_____ Pulse________

Visual Acuity R_____/_____ L_____/_____ Hearing R_____/_____ L_____/_____

MEDICAL EXAM	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Lungs		
Abdomen (hernia, spleen, liver)		
Genitalia		
Skin		
Neuromuscular Function		
FEMALE: Menstrual Cycle		
MUSCULOSKELETAL EXAM		
Neck		
Back		
Spine (cervical, thoracic, lumbar)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

LABORATORY:

Urinalysis: Protein____________ Glucose _____________

*Tuberculin Test _________________________

*Chest X-Ray (Results/Date) _______________

*Other Lab Work _________________________
(*If ordered by Physician)

IMMUNIZATION DATES:

__________ Tetanus __________ MMR, __________ Hepatitis B __________ Chicken Pox

Clearance

☐ The Student-Athlete is cleared for athletic participation.

☐ The Student-Athlete is cleared for athletic participation after completing evaluation/rehabilitation for the following condition:

____

☐ The Student-Athlete is NOT cleared for the following sport(s):

____

Physicians Name (printed): ___________________________________

Address: ____

Phone: (_____) ________________________

(Please provide the official office stamp for validation)

I have noted the history of and examined this student-athlete, finding him/her able to safely participate in intercollegiate athletics.

Physician Signature: ____, M.D.

Date of Examination: _________________

CCBC ATHLETIC TRAINING -CATONSVILLE, DUNDALK, ESSEX
2009-2010 ACADEMIC YEAR

Authorization for the Release of Medical Records and Protected Health Information

I, ________________________________, hereby authorize any healthcare provider involved in my care to release my medical records, which were generated based on my visit(s) to its facility for the purpose of medical examination, evaluation and treatment to the Certified Athletic Trainer affiliated with CCBC. I understand that the release of my medical information will be used for my health and safety during the course of my participation in athletics, and that the Certified Athletic Trainer involved in my case has been employed by CCBC through Union Memorial Sports Medicine as an approved medical provider.

The medical information and participation status obtained may also be disclosed to coach(es) for your health and safety, or to university administrators and academic counselors to support your academic progress, and to sports information staff and members of the media regarding your participation status.

The medical records authorized for release include, but are not limited to, all reports, findings, recommendations, test results, office notes, X-rays, other films, scans, slides, studies or any other information, documents or other items that concern my medical condition, diagnosis, treatment, prognosis, or ability to participate in an organized athletic program.

This authorization is valid for the academic year Aug 20___ - Aug 20___. I understand that I may revoke this authorization in writing at any time. Should I choose to revoke this authorization, I am aware that this may prevent the Certified Athletic Trainer from obtaining the medical information that may be needed to properly treat my condition, which may ultimately delay my return to athletic participation.

____________________________________ ____________________
Athlete's Name (Printed) Date of Birth

____________________________________ ____________________
Athlete's Signature Date

____
Parent / Guardian's Name (Printed if Athlete is under Age of 18)

____________________________________ ____________________
Parent / Guardian's Signature Date

STUDENT-ATHLETE EMERGENCY / INSURANCE INFORMATION
CCBC ATHLETIC TRAINING -CATONSVILLE, DUNDALK, ESSEX
2009-2010 ACADEMIC YEAR

Student-Athlete:___________________________________ Social Security #_______-______-_________

Birthdate: _____/_____/______ Sport: ________________________________

Emergency Contact Information

Father: ________________________________ Mother: ________________________________

Address: ________________________________ Address: ________________________________

________________________________ ________________________________

Day Phone: ________________________________ Day Phone: ________________________________

Evening Phone: ___________________________ Evening Phone: ___________________________

Emergency Contact: _________________________ Phone: Day ___________________ Evening: ___________________
(Other than Parent)

Insurance Information

You may be asked to present proof of medical insurance.

The following information will allow us to facilitate scheduling medical appointment with physicians and/or medical offices.

Policy Holder: ______________________________ Employer: ______________________________

Policy Holder Birthdate: _____/_____/______ Soc. Sec. #: _______-_______-_______

Insurance Carrier: ____________________________ Policy #: __________________________________

Group Name/#: ______________________________

Please Circle:

Health **M**aintenance **O**rganization (HMO) Supplemental Plans (Please attach card and or plan information)

Point **O**f **S**ervice (POS) Dental Yes No

Preferred **P**rovider **O**rganization (PPO) Prescription Plan Yes No

Commercial (i.e. BC/BS, Aetna, Conn. General)

Does your insurance require you to see a primary physician for a referral BEFORE diagnostic tests or seeing a specialist? Yes No

Primary Physician (PCP) is: ______________________________________ Phone: ____________________________
(Required for HMO, POS, and HMO/PPO combination plans)

Acceptance of Risk/Liability Waiver Affidavit

I. I understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me.

II. I understand that I must refrain from practices or games during medical treatment until I am discharged from treatment by the team physician and/or certified athletic trainer.

III. I understand and accept the risks of injury, permanent disability, and death that are inherent in the sport(s). By signing below, I pledge to do the best to reduce these risks by keeping in the best possible condition and following the advice of the team physician, attending physician, certified athletic trainer, and/or coaching staff concerning the prevention, treatment, and rehabilitation of athletic injuries.

Insurance and Treatment Consent

IV. I grant permission to the sports medicine staff to hospitalize and secure treatment for myself for any athletic injuries. If the athlete is a minor, the undersigned parent grants permission to the sports medicine staff to hospitalize and secure treatment for my son/daughter.

V. I further understand that CCBC does **NOT** carry athletic insurance for student-athletes **for any injury**. I will be responsible for all expenses of any incurred injury. I understand that I **MUST** have private insurance to participate in CCBC athletics.

VI. Permission is herby granted to the certified athletic trainer of CCBC to proceed with any medical or first aid treatment for the above named participant. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made to contact me in the most expeditious manner possible. In the event that I cannot be reached, the treatment necessary for the best interest of the above-named participant may be given

I, the undersigned, have read and understood the preceding medical policy statement and agree to follow its procedures and hereby give consent.

______________________________ ______________________

Signature of Student - Athlete **Date**

____

Name of Student – Athlete (print)

______________________________ ______________________

Signature of Parent/Guardian (if student-athlete is under the age of 18) **Date**