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 1st 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:	Return all forms to **SCC** if you are competing in any of the following sports:
• Baseball • Basketball-Women • Soccer - Men • Softball • Volleyball	• Basketball-Men • X-Country-M/W • Golf-M/W • Soccer-Women • Tennis-M/W • Track & Field-M/W
Nancy.Zacher@ccs.spokane.edu ■ 509 533-3630 Spokane Falls Community College * MS 3070 3410 W Fort George Wright Drive Spokane, WA 99224-5288	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 ☐ SCC ☐ SFCC ☐ BOTH	SPORT(S)	SCHOOL YEAR
FULL NAME		☐ MALE ☐ 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?	☐ YES	☐ NO

ATHLETIC PARTICIPATION

Have you participated in an intercollegiate CONTEST/EVENT since high school?	☐ YES	☐ NO
Have you participated in an intercollegiate PRACTICE since high school?	☐ YES	☐ 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? ☐ YES ☐ NO	If YES, name the team
When was the last time you participated?	Have you notified the team you are leaving? ☐ YES ☐ NO

LETTER OF INTENT

Have you ever signed a Letter of Intent? ☐ YES ☐ NO	If YES, for what sport?	
College	City/State	Year:

AMATEURISM

Have you participated on or tried out for a professional team?	☐ YES	☐ NO
Have you ever played with, received payment from, or signed a contract to play with a professional team?	☐ YES	☐ 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?	☐ YES	☐ NO
Have you received any other (non-athletic) scholarship and/or aid from this college for this academic year?	☐ YES	☐ 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?			☐ YES	☐ NO
Since your decision to attend, have any friends/relatives also chosen to attend?			☐ YES	☐ 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

Community Colleges of Spokane

PHYSICAL EDUCATION, ATHLETICS, RECREATION & WELLNESS ■ SPOKANE SASQUATCH ■ HOME OF THE BIGFOOT

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509-533-7230 Office ■ 509-533-8609 Fax ■ www.scc.spokane.edu

Spokane Falls Community College ■ MS 3070
3410 W Ft. Wright Drive ■ Spokane, WA 99224-5288
509-533-3630 Office ■ 509-533-4102 Fax ■ www.spokanefalls.edu

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) _____
LAST FIRST MI

ATTENDING ☐SCC ☐SFCC ☐BOTH SID # | | | | - | | | - | | | | |

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 1st 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 my 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.

FULL NAME (PRINT) _____ SID# | | | | - | | | - | | | | |
LAST FIRST MI

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		☐YES	☐NO
2. Heart Attack		☐YES	☐NO
3. Died suddenly before age 50 years		☐YES	☐NO
4. Neuromuscular Disease		☐YES	☐NO
5. Diabetes		☐YES	☐NO
6. High Blood Pressure		☐YES	☐NO
7. Sickle Cell Trait/Anemia		☐YES	☐NO
8. Marfan Syndrome		☐YES	☐NO
9. Stroke		☐YES	☐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 **YES**, please list the age at which your diabetes began as well as all medications your take for this condition.		☐YES	☐NO
2. Do you have of have you ever had an <u>epileptic seizure</u>? If **YES**, when?		☐YES	☐NO
3. Have you ever suffered from or been diagnosed with <u>Asthma</u> or <u>Exercise Induced Asthma</u>? If **YES**, what medication are you taking to control it?		☐YES	☐NO
4. Do you have any <u>heart disease, disorder or murmur</u>? If **YES**, describe and list any medication you are taking.		☐YES	☐NO
5. Have you ever been tested for a heart condition? If so, please list the test. (EKG, echocardiogram, stress test)		☐YES	☐NO
6. Do you have <u>Sickle Cell Trait/Anemia</u>?		☐YES	☐NO
7. During the last 12 months have you had any type of problem with intolerance to exercise?		☐YES	☐NO
8. Have you ever passed out before, during or after exertional activity?		☐YES	☐NO
9. Have you ever had trouble with dehydration, heat intolerance, heat cramps, heat exhaustion or heat stroke?		☐YES	☐NO
10. Have you ever had an injury to an internal organ?		☐YES	☐NO
11. Have you ever lost full use of any organ, either temporarily or permanently? (Eyes, Ears, Kidneys, Lungs, etc.)		☐YES	☐NO
12. In the past 24 months have you been treated for the following?			
Mononucleosis		☐YES	☐NO
Pneumonia		☐YES	☐NO
Tuberculosis		☐YES	☐NO
Infectious Virus		☐YES	☐NO
13. Do you have a vision defect in either one or both eyes?		☐YES	☐NO
14. DO you wear glasses during activity?		☐YES	☐NO
15. Do you wear contacts during activity?		☐YES	☐NO
16. Do you wear dental appliances? ☐YES ☐NO	Do you wear them during activity?	☐YES	☐NO
17. Have you had a tetanus shot in the last 3 years?		☐YES	☐NO
18. Have you ever received the Hepatitis B (HBV) Vaccination?		☐YES	☐NO
19. Any other medical conditions?		☐YES	☐NO

FULL NAME (PRINT) _____ SID# | | | | - | | | - | | | | |
LAST FIRST MI

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

Aspirin	☐YES	☐NO	Penicillin	☐YES	☐NO	Acetaminophen	☐YES	☐NO	Bee Stings	☐YES	☐NO
Codeine	☐YES	☐NO	Erythromycin	☐YES	☐NO	Novocain or other anesthetics	☐YES	☐NO	Iodine	☐YES	☐NO
Sulfa Drugs	☐YES	☐NO	Ibuprofen	☐YES	☐NO	Tetnus antitoxin or serums	☐YES	☐NO	Latex	☐YES	☐NO
Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If **YES**, please list those allergies here:										☐YES	☐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	☐YES	☐NO		Menstrual Cramps	☐YES	☐NO		Scanty Flow	☐YES	☐NO	
Painful Menstruation	☐YES	☐NO		Irregular Periods	☐YES	☐NO		Excessive Flow	☐YES	☐NO	
Are currently taking Birth Control Pills?			☐YES	☐NO	If **YES**, what type are you taking?						

E. EATING DISORDERS:

	Use this column to briefly explain YES answers		
1. Diagnosis of anorexia? If **YES**, when and where?		☐YES	☐NO
2. Diagnosis of bulimia? If **YES**, when and where?		☐YES	☐NO
3. A problem with food bingeing?		☐YES	☐NO
4. Do you sometimes or often induce vomiting after eating?		☐YES	☐NO
5. Taken laxatives to lose weight?		☐YES	☐NO

F. CONCUSSIONS:

1. Have you ever had a concussion? If **YES**, please list the dates and how long the symptoms lasted for each.		☐YES	☐NO
2. Have you ever been hospitalized for any of the concussions you sustained? If **YES**, please list the dates.		☐YES	☐NO
3. Have you ever been knocked unconscious? If **YES**, please list the dates.		☐YES	☐NO

G. CURRENT MEDICATIONS:

1. Are you currently taking any prescription medications? Including supplements and vitamins.	☐YES	☐NO
If **YES**, please list all with **DOSAGE** information and **EXPLAIN** purpose:		

FULL NAME (PRINT) _____ SID# | | | | - | | | - | | | | |
LAST FIRST MI

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?		☐YES	☐NO

I. SPINE:

1. Have you ever injured your lower back or suffered from chronic low back pain?		☐YES	☐NO
2. Were you ever diagnosed with a spinal defect of any type?		☐YES	☐NO
3. Have you ever had back surgery?		☐YES	☐NO

J. NECK:

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

K. SHOULDER:

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

L. ELBOW, WRIST, HAND, FINGER:

1. Have you ever had an elbow injury or problem?		☐YES	☐NO	☐L	☐R
2. Have you ever had a wrist injury or problem?		☐YES	☐NO	☐L	☐R
3. Have you ever had a hand or finger injury?		☐YES	☐NO	☐L	☐R
4. Do you have a finger deformity as a result of an injury? If **YES**, which finger?		☐YES	☐NO	☐L	☐R
5. Have you ever had elbow, wrist, hand or finger surgery?		☐YES	☐NO	☐L	☐R

M. HIP:

1. Have you ever injured either hip?		☐YES	☐NO	☐L	☐R
2. Have you ever had hip surgery?		☐YES	☐NO	☐L	☐R

FULL NAME (PRINT) _____ SID# | | | | - | | | - | | | | |
LAST FIRST MI

N. KNEES:

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

O. ANKLES:

1. Have you ever sustained an ankle injury?		☐YES	☐NO	☐L	☐R
2. Have you ever had surgery on your ankle(s)?		☐YES	☐NO	☐L	☐R

P. FEET AND TOES:

1. Have you ever had a foot or toe injury?		☐YES	☐NO	☐L	☐R
2. Have you ever had a problem with bunions?		☐YES	☐NO	☐L	☐R

Q. MUSCLE INJURIES:

1. Have you ever had a severe muscle pull or strain? **What muscle(s) and when?**		☐YES	☐NO
2. Has this injury reoccurred? **If YES, list the muscle(s) involved and date(s)**.		☐YES	☐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.

FULL NAME (PRINT) _____ SID# | | | | - | | | - | | | | |
LAST FIRST MI

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 _____

Community Colleges of Spokane

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509-533-3630 Office ▪ 509-533-4102 Fax ▪ www.spokanefalls.edu

ATHLETE'S INSURANCE INFORMATION 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**.

FULL NAME (PRINT) _____
LAST FIRST MI

SSN # | | | | - | | | - | | | | | SID # | | | | - | | | - | | | | |

SCHOOL YEAR _____ E-MAIL _____

☐MALE ☐FEMALE BIRTHDATE _____ AGE _____
MONTH/DAY/YEAR

SPORT(S) _____ ☐FRESHMAN ☐SOPHOMORE

LOCAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____

PARENT/GUARDIAN'S INFORMATION

PARENT/GUARDIAN'S NAME _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER NAME _____ EMPLOYER PHONE _____

E-MAIL _____

DO YOU HAVE INSURANCE COVERAGE? ☐YES ☐NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION

*** * * ATTACH A COPY OF YOUR INSURANCE CARD FRONT AND BACK * * ***

This is REQUIRED prior to participation even if you have provided it in previous years.

PRIMARY INSURANCE

INSURANCE COMPANY NAME _____ PHONE _____

CLAIMS PAYING OFFICE _____

CITY _____ STATE _____ ZIP _____

POLICY NUMBER _____ GROUP NUMBER _____

SUBSCRIBER'S NAME _____ RELATIONSHIP _____

The school athletic insurance policy is excess coverage to any other payable insurance plan. Any cost for medical expenses incurred as a result of accidental injury while participating in the school athletic program will be reduced by the amount collectable from any other insurance plan. If no existing primary insurance is in effect, payments will be made according to the schedule of benefits of the athletic accident policy. Primary insurance includes personal insurance and coverage under parental insurance. If, for any reason, the student's primary insurance does not cover your charges in full or denies your claim, **YOU ARE RESPONSIBLE FOR THE BALANCE.**

I hereby authorize any hospital, trust fund, employer, insurance company, health care provider, or other person who has attended me or any dependent to disclose any and all information with respect to any illness or injury, medical history, consultation, prescriptions, treatment, and provide copies of all hospital or medical records when requested to do so by the Athletic Insurance Company.

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.

STUDENT-ATHLETE SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (IF UNDER 18) _____ DATE _____

Community Colleges of Spokane

PHYSICAL EDUCATION, ATHLETICS, RECREATION & WELLNESS ■ SPOKANE SASQUATCH ■ HOME OF THE BIGFOOT

Spokane Community College ▪ MS 2050
1810 N Greene Street ▪ Spokane, WA 99217-5399
509-533-7230 Office ▪ 509-533-8609 Fax ▪ www.scc.spokane.edu

Spokane Falls Community College ▪ MS 3070
3410 W Ft. Wright Drive ▪ Spokane, WA 99224-5288
509-533-3630 Office ▪ 509-533-4102 Fax ▪ www.spokanefalls.edu

STUDENT-ATHLETE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

FULL NAME (PRINT) _____ SID# | | | | - | | | - | | | | |
LAST FIRST MI

I hereby authorize **Community Colleges of Spokane** and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in intercollegiate athletics to the **Athletic Director, Associate/Assistant Athletic Directors, Athletic Training Staff and related health care providers (MD specialists, therapists, etc.), Coaches, Sports Information Director, and local media** for the purposes of:

- **Decision making about and plan for my care and/or treatment**
- **Referral, consultation and coordination of with other health care providers for my care and treatment**
- **Determination of my eligibility for health insurance benefits or coverage**
- **Releasing information to the media when a condition or injury affects my ability to participate**
- **Performance of office or administrative functions that support the athletic training department's effort to provide me with effective health care**
- **Facilitation of any other reason permitted by law**
- **Promotion of Community Colleges of Spokane athletics**

I am making this authorization/consent voluntarily to release my health information otherwise protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA); Chapter 70.02 RCW, or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). I understand that my signing of this authorization is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the authorization requested for this disclosure. I also understand that I am not required to sign this authorization in order to be eligible for participation in NCAA or conference athletics.

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 on this authorization.

STUDENT-ATHLETE SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (IF UNDER 18) _____ DATE _____

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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) _____