GLENDALE COMMUNITY COLLEGE

Sports Medicine

Pre-Participation Physical Examination Packet

All of the following forms must be completed COMPLETELY and turned into a GCC Certified Athletic Trainer prior to ANY participation in athletics.

- ☐ Pre-participation Physical Examination History Form (bring to physical exam)
  - o **Exam must include EKG**
- ☐ Physical Examination Form (bring to physical exam)
- ☐ Assumption of Risk and Release of Liability
- ☐ FERPA/HIPPA Confidentiality Form
- ☐ Athletic Accident Insurance
- ☐ Concussion and Head Injury Acknowledgement
- ☐ Student-Athlete Travel Emergency Information

Do not turn this physical packet in to a coach or anyone other than an Athletic Trainer at GCC.

Glendale Community College clearance will be issued to an athlete only on completion of these requirements. Non-completed physicals will be rejected.

Student athletes, if eligible are covered by: The Maricopa Community Colleges: Student Accident Insurance Plan. Before seeking treatment for an accident, athletes must file a claim form available from a Certified Athletic Trainer or Student Services. It is the athlete's responsibility to seek out and follow up with this insurance plan. Failure to do so may result in forfeiture of coverage.

Thank You,

Athletic Training Staff

MCCCD PRE-PARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent (if the student is a minor) prior to seeing the physician.)

Name _____ Date of Exam _____

Permanent Address _____ City _____ State _____ Zip _____

Sex _____ Age _____ Grade _____ Phone _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines: _____ ☐ Pollens ☐ Food: _____ ☐ Stinging Insects: _____

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery? Explain procedure & List Dates		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down-syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

MCCCD PRE-PARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

EKG (Current EKG REQUIRED) Attach EKG Result Sheet & Clearance						
EKG Date	MM	DD	YY		NORMAL	ABNORMAL FINDINGS

Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the athlete/parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print)_____ Date _____

Address _____ Phone _____

Signature of Physician _____ MD, DO, PA-C, NP

MARICOPA
COMMUNITY COLLEGES

MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT
2411 West 14th Street, Tempe, AZ 85281-6942

GENERAL ASSUMPTION OF RISK & RELEASE OF LIABILITY

For Students in Athletic Programs

Caution: This is a release of legal rights. Read and understand it before signing.

The Maricopa County Community College District is a public educational institution. References to College ("College") include all of the Colleges within the Maricopa County Community College District ("MCCCD"), its officers, officials, employees, volunteers, students, agents, and assigns.

I, _____, ID/MEID, _____, freely choose to participate in the _____ Athletic Program (henceforth referred to as the "Program"). In consideration of my participation in this Program, I agree as follows:

RISKS INVOLVED IN PROGRAM: (Specific hazards in this Program's activity include but are not limited to.)

Participation in athletic activities may result in injury, from activities such as pre-season physical examinations, instruction of correct sports technique, strength conditioning, and practice sessions. Injuries may include but not limited to, sprains, strains, contusions, cuts, fractures or broken bones, concussion, torn muscles or tendons, dislocations, and heat related illness to various parts of the body. The injury may range from minor to severe and may result in deformity, paralysis, or even death.

HEALTH AND SAFETY: I understand it is my responsibility to consult with a medical doctor with regard to my personal medical needs. I state that there are no health-related reasons or problems that preclude or restrict my participation in this Program. I have obtained the required immunizations, if any.

I recognize that College is not obligated to attend to any of my medical or medication needs, and I assume all risk and responsibility therefore. In case of a medical emergency occurring during my participation in this Program, I authorize in advance the representative of the College to secure whatever treatment is necessary, including the administration of an anesthetic and surgery. College may (but is not obligated to) take any actions it considers to be warranted under the circumstances regarding my health and safety. Such actions do not create a special relationship between MCCCD and me. I release MCCCD, its officers, officials, employees, volunteers, students, agents and assigns from all liability for any bodily injury or damage I sustain as a result of any medical care that I receive resulting from my participation in Program, as well as any medical treatment decision or recommendation made by an employee or agent of MCCCD. I agree to pay all expenses relating thereto and release College from any liability for any actions. I have been advised that I am covered under a student accident insurance policy for injuries sustained while participating in athletics at MCCCD. The student accident insurance policy is secondary to my personal health insurance. I understand that any outstanding debts incurred as a result of medical treatment for that injury is my sole responsibility.

ASSUMPTION OF RISK AND RELEASE OF LIABILITY: Knowing the risks described above, and in voluntary consideration of being permitted to participate in the Program, I agree to release, indemnify, and defend College and their officials, officers, employees, agents, volunteers, sponsors, and students from and against any claim which I, the participant, my parents or legal guardian or any other person may have for any losses, damages or injuries arising out of or in connection with my participation in this Program.

SIGNATURE: I indicate that by my signature below that I have read the terms and conditions of participation and agree to abide by them. I have carefully read this Release Form and acknowledge that I understand it. No representation, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. This Release Form shall be governed by the laws of the State of Arizona which shall be the forum for any lawsuits filed under or incident to this Release Form or to the Program. If any portion of this Release Form is held invalid, the rest of the document shall continue in full force and effect.

Signature of Program Participant	**Date**
Signature of Parent/Legal Guardian (if student is a minor)	**Date**

This form authorizes Maricopa County Community College District (MCCCD) and its colleges to release certain personal information about you for educational purposes, including information that may be subject to the Family Education Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please read it carefully.

"Personal information" means specific information about you, including education records and personal health information, that MCCCD or its college(s) disclose: as a condition to permitting you to participate in college intercollegiate athletics; to benefit you in pursing athletics beyond MCCCD; to address your health as you play college intercollegiate athletics; or to highlight the colleges' intercollegiate athletics programs or your participation in them. It includes, as is appropriate to the specific use, your name, address, telephone number, date and place of birth, medical or health conditions, major field of study, participation in officially recognized activities and intercollegiate athletics, weight and height, dates of college attendance, degrees and awards, grade point average, email address, intercollegiate athletics in which you have participated and positions played, the name of your high school(s), the name of any other postsecondary institution you have attended, and your home town. The term also includes any photo, portrait, video clip, or other image of you created by any person for or on behalf MCCCD, its colleges or any other educational institutions that you have attended.

By signing this form, I certify that:

1. I have read and understand the definition of "personal information" specified in this form.

2. I authorize the release of personal information for the purposes specified in this form except that listed here: _____
   _____

3. I authorize FULL DISCLOSURE of personal information concerning any athletic injury I may sustain while participating in intercollegiate athletics at a college within MCCCD.

4. I understand that some or all of the following persons may be told about my health conditions: coaches, media, parents, athletic directors, team physicians, doctors' staff, referral sources, and MCCCD insurance brokers, insurance companies, and/or third-party claims administrators.

5. I authorize the use and disclosure of personal information for the following purposes:

   - In promotional literature or video presentations about college athletic programs or about MCCCD in general;
   - In any Internet website maintained by or for the benefit of MCCCD and its colleges;
   - To disseminate to the National Junior College Athletic Association concerning my participation in inter-collegiate athletics;
   - To include in any program or publication about an athletic event sponsored by MCCCD or its colleges or by any other organization and in which MCCCD or its colleges is participating;
   - To disseminate to other postsecondary institutions in connection with their recruitment activities;
   - To release to any newspaper, broadcasting entity, or any other media outlet;
   - To disseminate to any high school or other educational institution that I have attended.

I understand that I have the right not to consent to the release of my education records and to receive a copy of them on request. This consent shall remain in effect until revoked by me, in writing, and delivered to MCCCD. Any revocation will not affect disclosures that MCCCD made before receiving my revocation.

_____ _____

Signature of Student or Parent/Guardian (if student is a minor) Print Name of Student

_____ _____

Print Name of Parent/Guardian if applicable Sport

_____

Date:

Student Accident Insurance

(All athletic related injuries must be reported within 72 hours of the incident to the College Athletic Department)

Participation in all sports requires an acceptance of risk of injury, from activities such as pre-season physical examinations, practice sessions, instruction of correct sports technique. We attempt to provide a safe, competitive environment for all student athletes.

As an athlete at Maricopa County Community College District (MCCCD) you are provided with a student accident insurance policy. This student accident insurance policy is **NOT** a health insurance policy and may not be used in cases of illness. **This student accident insurance policy is to provide secondary coverage to your personal health insurance policy for injuries sustained while participating in intercollegiate athletics.**

This means that your personal health insurance (primary insurance) carrier **WILL BE** utilized and they will pay the student's normal benefits before the Colleges student accident policy will pay any supplemental benefits subject to policy terms and conditions. For example: if you belong to an HMO or PPO (CIGNA, Intergroup, Aetna, BC/BS, etc.), you **must** follow their procedure for filing a medical claim. After your private health insurance has paid its portion of the benefits, then the student accident insurance policy **may** apply to the remaining portion of the medical bill. As with all insurance carriers, the student's accident insurance policy has its restrictions and exclusions. In addition, the student accident insurance policy will only pay up to the limits and within the restrictions of the policy. If this is the case, the remaining balance after both the primary insurance and student accident insurance have been expended, the remaining balance **is the sole responsibility of the student athlete.**

It is important to note that all medical bills are the **responsibility of the student athlete. It is also the responsibility of the student athlete that all medical claims are properly filed with the student's own personal (primary) health insurance carrier, and with the College provided student accident insurance policy carrier.** If a medical claim is not filed properly or the primary health insurance carrier's guidelines are not followed, the student athlete will be responsible for any and all medical bills. At times, the student accident insurance policy will require additional information from the student athlete. Again, this is the sole responsibility of the student athlete to follow through with all additional requests from both the primary health insurance carrier and the student accident insurance policy companies. Failure to follow through with these requests can lead to failure and delay of any payment for medical treatments and the possibility of the student athlete going into collections.

Please note that in order to use the student accident insurance policy, the accident must occur within the policy year that is in effect at the time of the accident. Treatment must commence within 120 days of the date of the accident. **Treatment is limited to 52 weeks from the date of the accident.**

My signature verifies that I understand the student accident insurance policy provided by MCCCD is a secondary accident insurance policy to my personal (primary) health insurance policy. I also understand that if I do not follow the claim filing procedures set forth by my primary health insurance carrier and the College provided student insurance accident policy carrier, that my claim may be denied. **I also understand I am responsible for all medical bills.**

Printed name: _____ Sport: _____

Signature: _____ Date: _____

Signature of Parent/Guardian (if student is a minor): _____ Date: _____

___ I am NOT covered under a group insurance and/or have no primary health insurance coverage. I understand that the student accident policy is not a healthcare policy. It has a limit of 52 weeks of coverage from the date of the accident within the terms and conditions of the policy that is in effect for the accident policy year.

___ I am responsible for any medical bills not covered by the student accident insurance policy.

___ I am covered under the following plan:

Name of Group Insurance Company: _____

Group #_____ Policy #_____ Type: ___HMO ___PPO ___Other

Insurance Billing Address: _____

_____

Ins. Phone Number: _____

Primary Policy Holder _____ DOB _____ Relationship_____

Address_____ City _____ State_____ Zip_____

You must attach a copy of your insurance card (front and back) in order for this form to be complete.

In case of Emergency, please notify _____ Relationship_____

Home Phone _____ Business Phone _____ Cell Phone _____

Address_____ City_____ State_____ Zip_____

Athletes Medications: _____ Allergies: _____

Concussion and Head Injury Acknowledgement

The purpose of this acknowledgement form is to confirm that you have read and understand the information provided to you on the Glendale Community College athletics website related to potential concussions and head injuries occurring during participation in athletics. Before signing this form please read the "Concussion Fact Sheet" and "Helmet Warning Label" found next to the physical packet download link at: http://www.gccaz.edu/Athletics/12655.htm

I, as a student at Glendale Community College or as the parent/legal guardian (only if athlete is under 18 years old) have read the information material provided to us by Glendale Community College related to concussions and head injuries occurring during participation in athletic programs and understand its contents and warnings.

I also consent to the completion of a computerized concussion assessment both before participation and after all possible head injuries.
For more information on concussions and traumatic brain injury, visit:
http:// www.cdc.gov/injury

Name: _____ (printed) Date: _____

Signed: _____

Signature of parent/guardian (only if athlete is under 18 years old):

_____

Glendale Community College

Student-Athlete Travel Emergency Information

This form is to be completed by the student for the purpose of traveling with a GCC athletic team
The following information is needed in the event of an emergency while traveling with your team. Please fill completely. This form may be transported by a student-athlete or coach and will not remain in the confidential medical record. It will travel with our athletic teams in case of emergency. It will only be used for medical treatment.

Student Name: _____ Sport: _____

Phone: _____ Date Of Birth: _____

E-mail address_____

Address_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP)

EMERGENCY NOTIFICATION

Emergency Contact Name: _____

Phone #: _____ Alt. Phone# _____

ACCIDENT MEDICAL INSURANCE INFORMATION

Do you have personal medical insurance coverage which covers intercollegiate athletic injuries? ____YES ____ NO

_____
Insurance Company / Health Plan ID#/Policy#/Member# Group#

_____
Company Address Telephone Primary Care Physician and phone number (if necessary)

Height/Weight ***From physical exam***			Height _____ Weight _____
Pulse rate and Blood Pressure ***From physical exam.***			Blood Pressure_____ Pulse _____
Medicine Allergies or any other Allergies	Yes	No	List
Do you take any prescribed/ over the counter medications or other supplements	Yes	No	List:
Any current medical conditions	Yes	No	List:
Any previous concussions/head injuries	Yes	No	List:
History of High Blood Pressure, heart problems or family history of heart problems	Yes	No	
Do you wear contacts/glasses ?	Yes	No	