SWCID COMMUNITY COLLEGE FOR DEAF AND HARD OF HEARING PERSONS
SOUTHWEST COLLEGIATE INSTITUTE FOR THE DEAF
Education... for learning, for earning, for life.
3200 Ave. C, Big Spring, TX 79720 • (432) 264-3700

# MEDICAL INSURANCE INFORMATION FORM

Please return the completed form **along with a copy of your health insurance card (front and back) and prescription card** in the envelope provided.

## PART I: HEALTH INSURANCE

NAME OF ATHLETE _____
Social Security #

NAME OF INSURED PARTY (subscriber name)_____
Social Security #

RELATIONSHIP TO ATHLETE _____ INSURED PARTY'S DATE OF BIRTH_____

INSURANCE COMPANY NAME _____

PHONE NUMBER _____
AREA CODE NUMBER

CLAIMS ADDRESS _____

_____
CITY STATE ZIP

POLICY NUMBER (ID#)_____

GROUP NUMBER_____ GROUP NAME_____

1. Is your insurance company a PPO or HMO? HMO_____ PPO _____ NO_____
2. Do you need a referral from your Primary Care Physician to see another doctor? YES____NO___
   Name of Primary Care Physician _____ Phone #_____
3. Does your insurance company require pre-authorization for treatment, MRI, or other scans?
   Yes_____ No_____
   Pre-certification phone # _____
4. Do you have a prescription card? Yes _____ No_____

Southwest Collegiate Institute for the Deaf Athletics
3200 Ave C
Big Spring, TX 79720
(432) 264-5048 Office

# AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

**Part II**

The Family Education Right to Privacy Act is a federal law that governs the release of a student's education records, including personally identifiable information (name, address, social security number, etc.) from those records. Medical information is considered part of a student-athlete's educational record. In 1998 this law was amended and parents will be notified by Southwest Collegiate Institute for the Deaf officials when the student violates Federal, State, Local or college alcohol and/or drug laws or policies.

This authorization permits the athletic trainers, team physicians, and athletics staff (including coaches) of Southwest Collegiate Institute for the Deaf to disclose information concerning my medical status, medical condition, injuries, prognosis, diagnosis, and related personally identifiable health information to the authorized parties listed below. This information includes injuries or illnesses relevant to past, present or future participation in athletics at SWCID.

The purpose of a disclosure is to inform the authorized parties of the nature, diagnosis, prognosis, or treatment concerning my medical condition and any injuries or illnesses. I understand once the information is disclosed it is subject to re disclosure and is no longer protected.

I understand that SWCID will not receive compensation for its disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information disclosed under this authorization

I understand that I may revoke this authorization at any time by providing written notification to the Athletic Director. I understand revocation will not have any effect on actions the college has taken in reliance on this authorization prior to receiving the revocation. This authorization expires six years from the date it is signed.

_____ _____
Printed Name of Student-Athlete Sport

_____
Social Security #

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Parent/Legal Guardian Date
(If Student-Athlete is under 18 years of age)

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# MEDICAL LIABILITY RELEASE

I, _____ , fully accept all responsibility and assume all risk for my participation in the athletic program at Southwest Collegiate Institute for the Deaf.

I acknowledge receiving a letter concerning the policy that the Department of Intercollegiate Athletics adheres to, concerning medical insurance for the student-athlete. I have read and understood the Athletic Department's financial responsibility to a student-athlete who is injured during participation in intercollegiate sports at Southwest Collegiate Institute for the Deaf.

I hereby release Southwest Collegiate Institute for the Deaf, its officials, coaches and other employees, or agents from any and all claims or action resulting from any and all accidents, illnesses, or injuries I may sustain while participating in any or all phases of the Southwest Collegiate Institute for the Deaf Athletic Program. I certify that I am eighteen years of age or older and legally responsible for my actions.

_____ _____

**Student-Athlete Signature** **Date**

_____ _____

**Parent or Guardian Signature** **Date**
(Must have if not 18 years old)

A copy of this authorization shall be considered as effective, and as valid as the original.

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# INJURY POLICY

The Southwest Collegiate Institute for the Deaf Intercollegiate Athletic Department follows the policies set by the NJCAA. The athletic department will be responsible for medical services on student-athletes if the student-athlete is injured in practice or a game which was under the coaches' supervision with the coaches or his/her representative present. The word injury applies only to those ailments that are caused by the participation in practice or a game; for example, the athletic department cannot be responsible for the removal of tonsils or appendix by surgical procedure.

The process for securing medical aid for injury is as follows:

1. During the hours which the training room is open, report injuries in person to the Head Athletic Trainer.
2. At night or during hours when the training room is not open, contact the Head Athletic Trainer.
3. If you are sent to the doctor, you will be required to take a slip signed by the athletic trainer to present to the doctor. After your visit, you are to return the yellow slip to the athletic trainer who sent you to the doctor. If you do not take a slip to the doctor or do not return the yellow slip, you will be responsible for the expense.
4. If the doctor gives you a prescription, you will return that to the trainer and he will see that it is filled. If the athletic trainer has not approved a prescription, you will be responsible for the expense.
5. If for any reason you receive a medical bill, return it immediately to the trainer so that it can be paid.

**Student-Athlete Signature** **Date**

# Southwest Collegiate Institute for the Deaf

*Athletic*
*Department*

## MEDICAL HISTORY QUESTIONNAIRE

**PLEASE READ THE FOLLOWING CONSENT FORMS CAREFULLY:**
(If you are under 18 years of age, your parents must also sign)

The basic content of each is:

| | |
|---|---|
| I. Medical Consent: | Allows SWCID Athletic Trainers and Physicians to treat any injury you receive while at SWCID. |
| II. Release of Information: | Allows those listed to release information concerning your injuries to the media. |
| III. Release of Information: | Allows those listed to release information concerning your injuries to your Parents or Guardians. |
| IV. Release of Information: | Allows those listed to release any and all information concerning you, including records and others items listed, to professional, agents, scouts, etc. |
| V. Shared Responsibility For Sport Safety: | Acknowledges that there are certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks. |

**PART I – MEDICAL CONSENT**

I hereby grant permission to the Southwest Collegiate Institute for the Deaf Team Physicians and/or their consulting physician to render, any treatment or medical or surgical care that they deem reasonably necessary to the health and well being of the student-athlete.

I also hereby authorize the athletic trainers at Southwest Collegiate Institute for the Deaf who are under the direction and guidance of the Howard College Team Physician: to render any preventive, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to the health and well-being of the student-athlete.

Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

**Date**
Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:

**Student-Athlete Signature**

**Social Security Number**

**Parent or Guardian Signature**

**PART II – AUTHORIZATION FOR RELEASE OF INFORMATION**

This is to authorize the Howard College Athletic Trainers, Team Physicians, and Athletic Coaches to release medical information: to the SWCID Media Relations Department, and the various media outlets, any information concerning illness or injury relative to my past, or future participation in athletics at SWCID.

**Date**
Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:

**Student-Athlete Signature**

**Social Security Number**

**Parent or Guardian Signature**

**PART III – AUTHORIZATION FOR RELEASE OF INFORMATION**

This is to authorize the Howard College Athletic Trainers, Team Physicians, and Athletic Coaches to release medical information: to my parents or guardians, any information concerning illness or injury relative to my past, present, or future participation in athletics at SWCID.

**Date**
Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:

**Student-Athlete Signature**

**Social Security Number**

**Parent or Guardian Signature**

**PART IV – AUTORIZATION TO RELEASE INFORMATION**

I, _____, hereby authorize and request SWCID, the Board of Trustees, the Howard College Athletic Department and their duly authorized agents, servants or employees (including coaches, athletic trainers, and physicians): to furnish to all professional athletic teams, their scouts, representative agents, athletic trainers, physicians, servants or employees, any and all information concerning or having bearing upon my participation in athletics at SWCID. This authorization shall include, but is not limited to: information within their knowledge, or contained in any records under their supervision or control concerning my physical condition, illnesses, injuries, and any treatment, hospitalization, examination, X-rays, or otherwise, and to make such reports to such persons or organizations concerning myself as they may request; and I hereby fully discharge all parties to whom this authorization extends from any and all privilege in connection with the disclosure of information included in this authorization.

**Date**

Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:

**Student-Athlete Signature**

**Social Security Number**

**Parent or Guardian Signature**

**PART V – SHARED RESPONSIBILITY FOR SPORTS SAFETY**

Participation in sport requires an acceptance of risk of injury. Student-Athletes rightfully assume that those who are responsible for the conduct of the sport have taken reasonable precaution to minimize such risk, and that their peers participating in the sport will not intentionally inflict injury upon them.

There are periodic analyses of injury patterns done to help in modifications, refinements in the rules and safety decisions for the athlete. However, to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with the rule book is as insufficient as to rely on warning labels to produce compliance with safety guideline. "Compliance" means respect on everyone's part for the intent and purpose of a rule or guideline.

**I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating at SWCID.**

**Date**

**Student-Athlete Signature**

**Social Security Number**

**Parent or Guardian Signature**

# Southwest Collegiate Institute for the Deaf

*Athletic Department*

## FAMILY MEDICAL HISTORY QUESTIONNAIRE

NAME: Last_____ First_____ Middle_____

SS # _____-_____-_____ Date of Birth ____/____/____ Age_____ Sex_____ Sport_____

Home: Address_____ Phone # (_____)_____

City_____ State_____ Country_____ Zip_____

| **Has Any Blood Relative Ever Had:** | (Please Circle One) | | Who |
|---|---|---|---|
| | YES | NO | |
| Sudden Death (Before Age 55) | YES | NO | |
| Blood Diseases (Sickle Cell, Leukemia) | YES | NO | |
| Diabetes | YES | NO | |
| Epilepsy | YES | NO | |
| Gout | YES | NO | |
| Heart Disease | YES | NO | |
| Hemophilia | YES | NO | |
| High Blood Pressure | YES | NO | |
| Mental Disorders | YES | NO | |
| Stroke | YES | NO | |
| Tuberculosis | YES | NO | |
| Drug and/or Alcohol Dependency | YES | NO | |

### GENERAL MEDICAL HEALTH HISTORY

**Do you CURRENTLY have any of the following SYMPTOMS or PROBLEMS?:**

| | **YES** | **NO** | | **YES** | **NO** |
|---|---|---|---|---|---|
| Frequent Headaches | | | Abdominal Pain | | |
| Visual Changes | | | Muscle Cramps | | |
| Ringing in Ears | | | Frequent Nausea | | |
| Sore Throats | | | Frequent Vomiting | | |
| Sinus Congestion | | | Frequent Diarrhea | | |
| Breathing Difficulty | | | Rectal Bleeding | | |
| Recurring Coughing | | | Unusual Fatigue | | |
| Chest Pain | | | Trouble Sleeping | | |

## GENERAL MEDICAL HEALTH HISTORY (Continued)

Have you EVER had the following medical conditions?:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| High Blood Pressure | | | Skin Disease | | |
| Rheumatic Fever | | | Diabetes | | |
| Rheumatic Heart Disease | | | Sickle Cell Anemia/Cancer | | |
| Pericarditis | | | Anemia | | |
| Any Heart Disease? | | | Abnormal Bruising | | |
| Tumor, Growth, Cyst, Cancer | | | Abnormal Bleeding Tendency | | |
| Any ruptured organs? | | | Blood Disease | | |
| Hepatitis | | | Blood Clots | | |
| Jaundice | | | Kidney Disease | | |
| Gout | | | Kidney Stones | | |
| Pleurisy | | | Kidney Injury | | |
| Pneumonia | | | Blood in Urine | | |
| Polio | | | Frequent Urinary Infections | | |
| Bronchitis | | | Hearing Defect/Loss | | |
| Frequent Respiratory Infections | | | Ear Infection | | |
| Tuberculosis | | | Muscular Disease | | |
| Malaria | | | Birth Defects | | |
| Mumps | | | Appendicitis | | |
| Mononucleosis | | | Stomach Ulcer (Peptic) | | |
| Red Measles | | | Gastrointestinal Bleeding | | |
| Rubella | | | Constipation | | |
| Chicken Pox | | | Hemorrhoids | | |
| Asthma | | | Hernia | | |
| Exercise Induced Asthma | | | Arthritis | | |
| Recurrent Sinusitis | | | Joint Inflammation | | |
| Sinus Infection | | | Herpes (Oral, i.e. cold sore) | | |
| Nasal Polyps | | | Herpes (Genital) | | |
| Nose Fracture | | | Sexually Transmitted Diseases | | |
| Amnesia | | | Car or Air Sickness | | |
| Meningitis | | | Nervous Breakdown | | |
| Migraine Headaches | | | Mental Disorder | | |
| Seizure Disorder | | | Drug Dependency | | |
| Goiter, Thyroid Disease | | | | | |

**COMMENTS:**

# GENERAL MEDICAL HEALTH HISTORY (Continued)

**INTERNAL**

Were you born with a complete and functional set of paired organs? (eyes, ears, kidneys, ovaries/testicles, lungs):
(Check ) YES____ or NO____ ; If not, which organs were involved?_____

Have you ever had surgery to repair or remove any organ? (hernia, tonsils, appendix, spleen, etc.):
(Check) YES____ or NO____
1. If yes, which organ?:_____(Check) Repaired:____ or Removed:____ Date:_____
Physician:_____ Address of Physician:_____
2. If yes, which organ?:_____(Check) Repaired:____ or Removed:____ Date:_____
Physician:_____ Address of Physician:_____

**CARDIAC**

| | YES | NO |
|---|---|---|
| Have you ever felt dizzy, light-headed or passed out during or after exercise? | | |
| Have you ever had chest pain while exercising? | | |
| Have you ever had irregular heart beats or heart palpitations? | | |
| Have you ever been told you have a heart murmur? | | |
| Have you ever been seen by a heart specialist (cardiologist)? | | |
| If yes? Who: Date: | | |
| Have you ever had an echocardiogram? | | |
| Have you ever had a stress (heart) exam? | | |

**VISION**

| | YES | NO | |
|---|---|---|---|
| Have you ever been to an eye doctor? | | | Date of last visit:_____ Physician's name:_____ |
| Do you wear glasses now? | | | |
| If yes, Reading only: | | | Rx: R_____ |
| Distance only: | | | L_____ |
| All the time | | | |
| Do you wear contact lenses? | | | |
| If yes, Soft lenses: | | | Rx: R_____ |
| Hard lenses: | | | L_____ |
| Do you have a second pair?: | | | |
| Do you wear contact lenses/glasses to participate? | | | |
| Have you ever had an eye injury? | | | Date of incident:_____ Explain:_____ |
| Do you have a color vision problem? | | | |
| Have you ever worn a false eye? | | | |

**DENTAL – Do you now have or experienced any of the following?:**

| | YES | NO | COMMENTS |
|---|---|---|---|
| Do you have a bridge or false teeth? | | | |
| Have you ever fractured a tooth? | | | |
| Have you had a tooth knocked out? | | | |
| Do you wear a mouth protector? | | | |
| Do you wear orthodontic appliances? | | | |

**HEAT – Have you ever experienced any of the following?:**

| | YES | NO |
|---|---|---|
| Trouble with dehydration (Excessive loss of salt and water) | | |
| Heat Stroke | | |
| Heat Cramps (Due to fluid loss because of excessive heat) | | |
| Heat Intolerance | | |

# GENERAL MEDICAL HEALTH HISTORY (Continued)

**ALLERGIES - Are you allergic to. . .?:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Aspirin | | | Insect Bites/Stings | | |
| Codeine | | | Tetanus Antitoxin or Serums | | |
| Cortisone | | | Nail Polish or Cosmetics | | |
| Sulfa | | | Any Foods: | | |
| Anti-Inflammatories | | | Any other Drug: | | |
| Penicillin | | | Other: | | |
| Hay Fever | | | | | |

**DRUG, FOOD SUPPLEMENTS AND MISCELLANEOUS AGENTS**

Check the appropriate space according to YOUR use of the following items:

| | Never | Rarely | Occasionally | Frequently |
|---|---|---|---|---|
| Vitamins | | | | |
| Diet Pills | | | | |
| Sleeping Pills | | | | |
| Laxatives | | | | |
| Alcoholic Beverages | | | | |
| Antihistamines | | | | |
| Anti-Inflammatories | | | | |
| Caffeine | | | | |
| Tobacco | | | | |
| Creatine Monohydrate | | | | |
| Other | | | | |

**MISCELLANEOUS – Have you ever. . .?:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Worn hearing aids | | | Do you have any pins, staples, or wires in any part of your body | | |
| Stuttered or stammered | | | | | |
| Coughed up blood | | | Had any illnesses other than those already noted | | |
| Bled excessively after injury | | | | | |
| Been advised to have any operations | | | Have you ever missed a game because of illness | | |

**If yes, to any of the questions above, please explain and tell when it occurred:** _____

_____

_____

_____

**List all medications that you currently take:** _____

_____

_____

_____

**ORTHOPEDIC HISTORY QUESTIONNAIRE**

**PLEASE PLACE A CHECK IN EITHER THE "YES" OR "NO" BOX. IF YOU CHECKED "YES," INDICATE THE DATE AND COMMENTS ABOUT THE INJURY. IF YOU HAVE ANY QUESTIONS OR UNCERTAINTIES, PLEASE ASK ANY MEDICAL PERSONNEL FOR ASSISTANCE.**

**HAVE YOU EVER INJURED OR CONSULTED A DOCTOR ABOUT ANY INJURY TO THE. . . .**

| HEAD | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Unconscious | | | | |
| Dazed/Dizzy | | | | |
| Knocked Out | | | | |
| Concussion | | | | |
| Headaches | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| NECK | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Stretches | | | | |
| Pinches | | | | |
| Disk Injury | | | | |
| Dislocations | | | | |
| Burners/Stingers | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| CHEST WALL | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Fractured Collar Bone | | | | |
| Fractured Ribs | | | | |
| Sterno-Clavicular Joint Separation | | | | |
| Bruise | | | | |
| Pains | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

**ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)**

| LOWER BACK | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Nerve Pinches | | | | |
| Disk Injury | | | | |
| Referred Pain | | | | |
| Pain Down Leg | | | | |
| Numbness in Leg | | | | |
| Weakness in Leg | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| SHOULDERS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| A-C Separations | | | | |
| Dislocations | | | | |
| Partial Dislocations | | | | |
| Shoulder Slips Out of Place | | | | |
| Tendonitis | | | | |
| Bursitis | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pain w/ Overhead Activities | | | | |
| Arm Goes “Dead” After Trauma | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| UPPER ARMS/ FOREARMS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Strain | | | | |
| Dislocations | | | | |
| Casted/Splints | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

**ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)**

| ELBOWS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Bursitis | | | | |
| Dislocations | | | | |
| Joint Locking | | | | |
| Casted | | | | |
| Tendonitis | | | | |
| Bruise | | | | |
| Swelling | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| WRISTS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Tendonitis | | | | |
| Dislocations | | | | |
| Casted | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| HANDS/FINGERS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Dislocations | | | | |
| Casted/Splints | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

**ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)**

| PELVIS/HIPS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Groin Pulls | | | | |
| Torn Muscles | | | | |
| Dislocations | | | | |
| Casted | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| THIGHS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Quad Pulls | | | | |
| Hamstring Pulls | | | | |
| Torn Muscles | | | | |
| Calcium Deposits | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| KNEES | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Strained | | | | |
| Sprain Ligament | | | | |
| Torn Ligament | | | | |
| Torn Cartilage | | | | |
| Knee Cap Injury | | | | |
| Knee Cap Dislocation | | | | |
| Osgood Schlatter's | | | | |
| Bursitis | | | | |
| Swelling | | | | |
| Locking | | | | |
| Giving Away | | | | |
| Sudden Weakness, Shifting | | | | |
| Wear Braces | | | | |
| Casted | | | | |
| Arthritis | | | | |
| Chandromalacia | | | | |
| Grinding | | | | |
| Tendonitis | | | | |
| Jumper's Knee | | | | |

(cont.)

**ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)**

| KNEES (cont.) | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Pain w/ Stairs | | | | |
| Pain w/ Squats | | | | |
| Fractures | | | | |
| Arthrograms | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Arthroscopes | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| LOWER LEGS | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Shin Splints | | | | |
| Torn Muscles | | | | |
| Bruise | | | | |
| Injections | | | | |
| Pains | | | | |
| Painful – Tight Calf w/ Activity | | | | |
| Achilles Tendon Pain | | | | |
| Stress Fracture | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

| ANKLES | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprain/Strain | | | | |
| Dislocations | | | | |
| Casted/Splinted | | | | |
| Bruise | | | | |
| Instability | | | | |
| Giving Out | | | | |
| Weakness | | | | |
| Injections | | | | |
| Pains | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

**ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)**

| FEET/TOES | YES | NO | DATE | COMMENTS |
|---|---|---|---|---|
| Sprains | | | | |
| Turf Toe | | | | |
| Dislocations | | | | |
| Casted/Splinted | | | | |
| Bruise | | | | |
| Injections | | | | |
| Fractures | | | | |
| X-rays, CT, MRI | | | | |
| Hospitalized | | | | |
| Surgery | | | | |
| Missed Practice | | | | |
| Missed Games | | | | |
| Other | | | | |

**OTHER MEDICAL CONCERNS**

| | YES | NO |
|---|---|---|
| Have you had or do you now have any other medical problems or injuries not listed on this form? | | |
| Do you have any medical or health problems that you are currently receiving medical treatment for? | | |
| Is there any reason that you are not able to participate in athletics? | | |
| Are there any additional health problems you would prefer to discuss privately with our team physician? | | |

If any of the first three questions above were answered with "YES", please explain below:

_____
_____
_____
_____
_____
_____

The undersigned, herewith,

A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.
B. Certifies that the answers to these questions are correct and true.
C. Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
D. Fully realizes the Southwest Collegiate Institute for the Deaf Athletic Department cannot be held responsible for any previous medical condition(s) that he/she might have.

_____ _____

**Student-Athlete Signature** **Date**

Upon completion of this History Form, it is to be reviewed and signed by the Howard College Athletic Trainer.

_____ _____

**Athletic Trainer Signature** **Date**

# Pre-participation Physical Evaluation

Students Name_____ Sex_____ Age_____ Date of Birth_____

Height_____ Weight_____ Pulse_____ BP ____/____ (_____/_____,_____/_____)

Vision R 20/____ L 20/____ Corrected Y N Pupils: Equal_____ Unequal_____

**As a minimum requirement this Physical Examination Form must be completed prior to participation.**

| | Normal | Abnormal Findings | Initials* |
|---|---|---|---|
| **Medical** | | | |
| Appearance | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart-Auscultation of the heart in the supine position | | | |
| Heart-Auscultation of the heart in the standing position | | | |
| Heart-lower extremity pulses | | | |
| Pulses | | | |
| Lunges | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| **Musculoskeletal** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |

* Station-based examination only

## Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:_____
_____

☐ Not cleared for:_____ Reason:_____
Recommendations:_____
_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners.

Name (print or type)_____ Date of Examination:_____
Address:_____
Phone Number:_____
Signature:_____

**Must be completed before a student participates in any practice or game(both in-season and out of season)**

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# AUTHORIZATION STATEMENT

I do hereby understand and give the head coach or assistant coaches of my respective sport, the athletic director, or the head athletic trainer of Howard College, Big Spring, TX, permission to communicate with my parent(s) and/or legal guardian(s), former high school or college coaches, summer league coaches, prospective employers, educational or professional individuals that could further my educational or professional advancements concerning information about grades, compliance or non-compliance of SWCID, SWCID Athletic Department, or Howard College team policies, my mental or physical health, or progress in the area of my team at SWCID.

Further, the above persons may communicate with my instructors, coaches, professional staff, and administrators of SWCID concerning the above mentioned items.

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# ATHLETIC DEPARTMENT POLICIES OFFER

I have been informed that I may request to review the following policies for the athletic department at any time during regular office hours. I understand that these policies are available to me in the athletic training department or the athletic director's office and that any questions about these policies should be directed to either the athletic director or head athletic trainer.

1. Howard College Junior College District Intercollegiate Athletics Substance Abuse Program.
2. Howard College Athletic Injury/Accident Policy.
3. Howard College Athletic Medical Examination Policy.

| | |
|---|---|
| **Print Name** | **Signature** |
| **Social Security Number** | **Date** |

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# INSURANCE AND CLAIM INFORMATION

Southwest Collegiate Institute for the Deaf and our athletic department are committed to providing the best medical care possible through a full-time head athletic trainer and student trainer staff and an on-campus health clinic. Our entire purpose is to do the very best we can to ensure both athlete and parent(s) that medical coverage for injury/illness is a top priority and the ultimate goal is the complete restoration of health and well-being of the athlete.

**PAYMENT OF CLAIMS:** Through each department, many of the injury and illness issued can be addressed. In addition, the athletic department provides a secondary insurance policy that works with athletes injured in their sport and who posses medical coverage under a primary insurance plan. Claims are considered by Howard College's secondary policy after the primary insurance plan carried by the athlete has paid. The athlete is responsible for turning in the Explanation of Benefits received from the primary insurance plan to the head athletic trainer for secondary payment. If you do not carry a primary plan, our policy becomes a limited primary coverage. There could be unpaid medical charges under the limited primary plan. **The student athlete is responsible for these medical charges**. However, the head athletic trainer will review all unpaid balances and could make payment of any outstanding balance.
**Note: Non-athletic illnesses/injuries are not covered by the secondary plan.)**

**SUGGESTIONS:**

1. If you have a primary plan (on parent's insurance or your own) and it is a preferred plan for the area you live in, you may contact your local agent and see if your plan can be moved to Big spring under a physician in our community. Examples are PPO's, HMO's, and other type plans. If you are unable to use a physician in this area, you might consider traveling back to your hometown for treatment. This would ensure the primary care plan to be in effect. The secondary plan is not affected by location. This is the most cost effective claim payment. The head athletic trainer will be able to answer any questions you may have on our local physicians.
2. If your primary care plan will not allow you to move to a new area, your insurance agent could have information on an extended medical coverage plan for college students away from home that could be an attachment to the primary plan. These type plans are specifically for college students, usually not expensive, and are effective for the school year.
3. If you do not have a primary care plan, I would encourage you to consider purchasing a plan that would cover you while attending SWCID. The cost of purchasing one of these plans is far less than having extensive medical charges.

# Drug Test Consent Form

I _____ hereby consent to have samples of my urine collected and tested to determine if certain drugs are present. I understand that urinalysis testing is required by the Athletic Department of SWCID and is part of the approved policies governing the institution. The results of said test will be kept confidential and can only be viewed by the director of athletics, Head coach of my sport, Assistant Coach so designated by the head coach, the Head athletic trainer, Dean of students and any administrator so designated by the college.

If the results of said test show a positive use of illegal drugs, steroids or alcohol the athlete will have an opportunity to discuss the matter with the director of athletics, Head coach of my sport, Head athletic Trainer and the Dean of Students, and to present evidence of any rebuttal or mitigating circumstances which he or she feels important. Following this discussion, a decision concerning my participation in athletics at HCJCD will be made at that time by the Director of athletics, Head coach of my sport, Dean of Students, and the Head athletic trainer. The decision being one of the following:

1. A probationary period with immediate loss of scholarship for a designated period of time.

2. Suspension from the team with immediate loss of scholarship for the remainder of the school year.

3. Sanctions issued by the Dean of Students

Furthermore, if the results of said test show a positive use of illegal drugs, steroids or alcohol or other controlled substance, that athlete or their specimen can be retested to assure the athlete continues to show negative use of illegal drugs, steroids, or alcohol has occurred, and the cost of these test will possibly be charged to the student.

You are free to refuse to consent to drug testing under this program. However, upon declining participation in the testing program, which is designed to protect your health and reputation, you will not be eligible for a scholarship or to participate in any intercollegiate sport offered by SWCID. If you refuse to test for drugs as provided in this policy, after initially consenting, you shall be considered to have made a decision not to participate and will forfeit your scholarship immediately. **I also acknowledge that I have been provided with a copy of SWCID's drug testing policy.** I understand that under the Family Education Right to Privacy Act, That SWCID officials will release alcohol and drug violations and results of drug test to parents or legal guardians.

SWCID, its Board of Trustees, Its officers, employees and agents are hereby released from any legal responsibility or liability as a result of their compliance herewith.

_____

Print Name (Student Athlete)

_____ _____

Signature (Student Athlete) Date

## HOWARD COUNTY JUNIOR COLLEGE EMERGENCY INFORMATION CARD

Athlete's Name _____ D.O.B____/____/____Age_____

FIRST MI LAST

Athlete's Address_____

City_____State_____Zip_____

Athlete's Social Security Number_____/_____/_____

Sport_____

Do you have Hospital (Medical) Insurance? Yes_____ No_____

If yes, covered by: (Check One): Parent's Policy_____ Your Policy_____

If Parent's Policy: Father or Mothers' Name_____

Social Security Number _____

Date of Birth _____

Name of Insurance Company _____

Company Address _____

Insurance Certification # _____

Group # _____

Type _____

In case of Serious Accident or illness, permission is given for Emergency Treatment, Routine Immunization, X-Rays, Skin Tests for Diagnosis and Hospitalization.

**SIGNATURE OF PARENT / GUARDIAN / STUDENT ATHLETE, IF 18 YEARS OF AGE OR OLDER**

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Address: _____

Relationship: _____

Phone: Home_____

Business _____

Other _____

Family History: List serious illnesses of close relatives, example: Diabetes, Heart Disease, Tuberculosis, etc.: _____

_____

_____