



Dear Incoming Student-Athlete:

Welcome to the Community College of Rhode Island Department of Athletics. The following are some of the responsibilities of each student-athlete:

1. You should be registered and maintain through the conclusion of each semester enrollment in at least 12 credit hours to participate as a student-athlete at the Community College of Rhode Island.
2. We expect you to uphold the core values of CCRI Athletics, NJCAA Region XXI and the NJCAA National Office. As a representative of CCRI, you agree to take personal responsibility to consciously adhere to all other school policies, whether specific or implied, be they academic, athletic or judicial in nature.

Prior to the start of each new season, we host a meeting for all incoming student-athletes with the Team Administrator, Compliance Officer and Head Coach. Your coach will inform you of the meeting date and location. We ask that you bring the information listed below to the meeting.

The CCRI Team Administrators, Compliance Officer, Coaches, Athletics Trainer/Physician will need the following:

- Completed on the **attached form** Confidential Medical History and Physical Form
- Signed Accident Insurance Policy Form.
- Completed and Signed Athletics Contact and Accident Insurance form
- Completed and Signed Immunization Requirements Form
- Signed Student-Athlete Participant Liability Waiver Form
- Signed HIPAA Consent Form
- Completed Sports Information Form
- Completed Media Release Form
- Completed NJCAA Eligibility Form
- Signed FERPA Consent Form
- A copy of your Official High School Transcripts or GED and any CCRI transcripts if applicable
- A copy of all official transcripts from previously attended colleges or universities
- Non-US citizens – I-20 form, Military Form DD214
- Athletic Locker Agreement

All of the above forms along with a completed physical must be on file in the athletic department prior to tryouts, practice and/or play at the Community College of Rhode Island. Once all of the above information is completed and submitted to the CCRI Athletics Department your eligibility will be determined. You will not be allowed to participate, practice, scrimmage or compete prior to being declared an "Eligible Student-Athlete." **This process is completed and approved by Bev Wiley, Compliance Officer.**

The college's accident insurance plan is a secondary coverage plan. Medical expenses will be filed with your personal insurance company first and then filed with the college insurance company if any expenses were not covered. If you do not have personal insurance, then the college's accident insurance plan will be filed. The college's insurance plan only covers accidents occurring during athletic participation (practice and games). It does not cover benefits such as other medical conditions, illnesses, prescriptions, accidents occurring during non-athletic events, etc. Our coaches and athletic trainers will help you arrange for medical care, should you need assistance.

Good luck to everyone and LET'S HAVE A GREAT YEAR! GO KNIGHTS!

Sincerely,

A handwritten signature in black ink, appearing to read "K. Di...".

Director of Athletics

A handwritten signature in black ink, appearing to read "Bev Wiley".

Community College of Rhode Island

Department of Athletics



STUDENT - ATHLETE INFORMATION PACKET

2019 – 2020

Sport: _____

Second Sport: _____

- ☐ Official High School/GED Transcript.
- ☐ DD-214 (Military)
- ☐ I-20 (Non-citizen)
- ☐ Prev College(s) Official Transcripts
- ☐ Medical
- ☐ Shot Record
- ☐ Sports Information

DIRECTIONS:

Please complete each page and submit completed packet to your Head Coach.
This completed packet is due no later than the first scheduled team meeting.

The Head Coach will submit completed packets to your Team Administrator.
Failure to submit a completed packet will disqualify you from any form of athletics participation (practice, tryouts or competitive play) and will be returned to the coach for further review.

I have reviewed the packet and my signature verifies that this packet is completed as per Athletics Department Policy.

Student ID #

Print Name (Student-Athlete)

Date of Birth

Student-Athlete Email Address

Student-Athlete Phone #

Check one: ☐ Home ☐ Cell

Signature (Student-Athlete)

Date

Signature (Head Coach)

Date

Signature (Team Administrator)

Date

Signature (Athletic Trainer)

Date

Date of Physical

Signature (Compliance Officer)

Date



Dear Student-Athlete:

As an incoming or current Student-Athlete at the Community College of Rhode Island, we need to inform you of your rights regarding the release of educational records under the Family Educational Rights and Privacy Act (FERPA). Under the guidelines of FERPA, your rights are as follows:

- Right to seek amendment or correction of educational records;
- Right to have some control over the disclosure of information from education records except when release is permitted by law; and
- Right to file complaints with the Family Policy Compliance Office, United States Department of Education within 180 days of alleged violation.

Since you are a collegiate Student-Athlete, CCRI Athletics Department is often asked to release your transcripts and personal information to parents and prospective coaches. Under FERPA, our institution has the right to disclose information to the following without your written permission:

- School officials with a legitimate educational interest;
- Schools in which a student seeks or intends to enroll;
- Federal/State authorities for audit/evaluation/compliance activities;
- In connection with financial aid;
- State/local authorities pursuant to state statute adopted before 11/19/74;
- Studies for or on behalf of educational institutions;
- Accrediting organizations;
- Parents of a dependent student;
- In compliance with judicial order or lawfully issued subpoena;
- In connection with a health or safety emergency; and
- Yourself.

If you wish for us to release records to individuals other than from the above listed guidelines, we need for you to complete the attached Educational Records Release Form **upon each request**. If you have any questions, please contact your Head Coach or Team Administrator.

Sincerely,

A handwritten signature in black ink, appearing to be "K. Di...", written over a horizontal line.

Director of Athletics

*If you wish for us to release records to individuals other than from the listed guidelines, we need for you to complete the Educational Records Release Form (below) **upon each request**.*



Educational Records Release Consent Form

To: CCRI Registrar's Office
400 East Avenue
Warwick, RI 02886

From:

Name of Student

Student ID #

Street Address

City

State

Zip

Under Federal legislation, namely the Family Educational Rights and Privacy Act of 1974, I understand that my educational records cannot be released without my written permission to individuals other than deemed permissible by FERPA.

I, therefore, request that information listed below be released to the following:

Name

Street Address

City

State

Zip

Information to be released:

Purpose:

Signed this day of , .

Signature of Student

Student ID #



NJCAA Eligibility Affidavit

SPORT: _____ Date: _____

Fill in all applicable information on this form to assist in determining eligibility for the NJCAA.

Personal Information:

Student's Name: _____ Birth Date: ____/____/____ ID #: _____
(First, Middle, Last)

Student's College Address: _____
(Street Address) (City, State, Zip Code)

Phone Number(s) at College: _____ Email Address: _____

Foreign Born Students: Do you have an I-20 Form on file at this college? ☐ Yes ☐ No

Parental Information:

Parents' Home Address: _____
(Street Address) (City, State, Zip Code)

Phone Number: _____ Parents' Names: _____

High School Information:

Name of High School(s) you have attended: _____

City, State & Country: _____

Did you graduate? ☐ Yes* ☐ No High School Graduation Date (month/date/year): ____/____/____

Were you home schooled? ☐ Yes ☐ No Did you graduate? ☐ Yes* ☐ No

Did you earn a GED or State Department of Education approved high school equivalency test? ☐ Yes ☐ No

If yes, enter the date earned (month/date/year): ____/____/____

**Enclose a COPY of your High School Transcript, and GED Certificate or State Department of Education approved high school equivalency (if applicable).*

Additional Information:

1. Did you take any college credit classes while in high school? ☐ Yes* ☐ No

* If yes, from what college(s)? _____
If yes, then transcript(s) from each college must be on file at CCRI.

2. Have you ever signed a Letter of Intent form with any institution? ☐ Yes ☐ No

If yes, specify the College: _____ Date (day/month/year): ____/____/____

3. Have you ever participated in a sport in a country other than the United States? ☐ Yes ☐ No

Sport(s)? _____ Country: _____ Dates: _____

If yes, describe the situation: _____

4. Have you ever been **red-shirted** for a season? ☐ Yes ☐ No If yes, list the **dates** of that season, name of college, and describe the situation: _____

(Page 2 - NJCAA Eligibility Affidavit Continued)

5. Have you ever participated in practices, scrimmages, and/or games for an intercollegiate team other than this college?

☐ Yes ☐ No *If yes, name the school, date, sport, and describe the situation:* _____

6. Have you ever played on a club team at a college or university? ☐ Yes ☐ No *If yes, name the school, sport and dates:*

7. Do you currently play on any other sport teams (i.e. USAV, city recreational leagues, indoor soccer, AAU, etc.)?

☐ Yes ☐ No *If yes, please provide the name of team, location, and dates of participation:* _____

8. Have you ever received money beyond expenses for participating in any athletic event? ☐ Yes ☐ No

Did anyone on your team receive money beyond expenses for participating in any athletic event? ☐ Yes ☐ No

If yes, describe the situation: _____

If yes, the NJCAA Amateurism Questionnaire should be completed and included with the eligibility file.

List ALL Colleges Attended Full-Time and/or Part-Time after High School

All transcripts from all previous institutions must be included.

College: _____ Dates: _____ ☐ Full-time ☐ Part-time

College: _____ Dates: _____ ☐ Full-time ☐ Part-time

College: _____ Dates: _____ ☐ Full-time ☐ Part-time

Additional Explanations:

The NJCAA requires that you account for any time after high school graduation when you are not enrolled in college full-time. If you attended college part-time or were not attending college for any period of time following high school, please document your employment, military and/or unemployment history below. Please include months and years when referring to dates.

I understand that information falsified or omitted can make me ineligible for ALL future college competition in compliance with the National Junior College Athletic Association Eligibility Rules.

Student-Athlete Signature: _____ Date: _____

Coach Signature: _____ Date: _____



Athletic Locker Agreement

I _____ understand and acknowledge that the locker assigned to me is a privilege given to me as an athlete at the Community College of Rhode Island and that said privilege can be revoked at any time with cause.

I understand and acknowledge that my locker may be subject to inspection by Campus Police without notice at the request of school authorities with cause.

I understand that lockers are provided for the convenience of student athletes in the course of their studies and understand that in accordance with Community College policies, narcotics, illegal materials, stolen items, weapons or other materials detrimental to the safety of the school are strictly prohibited.

I understand that this agreement will be in effect for the duration of the academic year.

Signed: _____ Date: _____

Name: _____ CCRI ID#: _____



Sport

Student ID #

Sports Information

Please print clearly and complete all information as accurately as possible.

Last name, First name (or nickname), MI		Height	YR (Fr. or So.)	Contact #
High School/ State	Yr. Grad.	Hometown/State		Social Media ID's (Twitter/IG)
Hometown Newspaper(s):				
High School Varsity Sports Played (<u>Include sport, position or event and each year(s) played</u>)				
#1				
#2				
#3				
High School Sports Awards- Honors- Distinctions (<u>Include sport, position and yr.(s)</u>)				
#1				
#2				
#3				
Postgraduate, prep school or other junior college or college experience (<u>Include sport, position, yr.(s) and honors, if any</u>)				
#1				
#2				
CCRI sports played (<i>for returning athletes only</i> - include sport, position, yr. and honors, if any)				
#1				
#2				
#3				

This is to certify that I, _____, have reviewed and completed this form to the best of my knowledge and that I give permission for the information contained herein to be released to the junior college community or to the media for publication or broadcast purposes by the CCRI Sports Information Office.

- USE BACK OF SHEET IF NEEDED -



Photography & Imaging Release Form

I hereby give the Community College of Rhode Island, their successors and assigns and those acting under their permission or upon their authority or those by whom they are commissioned, the unqualified right and permission to reproduce, copyright, publish, circulate or otherwise use photographs of me, alone or in conjunction with other persons or characters real or imaginary, in any media of advising, publicity or trade in any part of the world for an unlimited period, and I hereby waive the opportunity or right to inspect or approve the finished photograph or the use to which it may be put or the advertising copy or photograph caused by optical illusion, distortion, alteration or made by retouching or by using parts of several photographs or by any other method.

I hereby assign and transfer to the Community College of Rhode Island Department of Athletics all my rights, title and interest in and to all negatives, prints and reproductions thereof; and I hereby warrant and state that I have not limited, restricted or excepted to the use of my photograph with any organization or person and do hereby release the Community College of Rhode Island and their successors and assigns of and from any and all rights, claims, demands, actions or suits which I may or can have against them on account of the use of publication of said photographs.

Signature: _____

Student ID: _____

Signed in the presence of: _____

Date: _____

If the student-athlete is under 18 years of age:

I, the undersigned, being the parent or guardian of the above person, do hereby consent to the above release and signature thereto.

Signature: _____

Signed in the presence of: _____

Date: _____

- FORWARD ORIGINAL TO SPORTS INFORMATION COORDINATOR -



Athlete Contact & Insurance Form

Athlete Information:

Last Name: _____ First Name: _____ Sport: _____

SSN: _____ Grade: _____ Gender: _____ DOB: _____

Local Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____ Cell Phone: _____

Primary Emergency Contact:

Last Name: _____ First Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Work Phone: _____ Cell Phone: _____

Secondary Emergency Contact:

Last Name: _____ First Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Work Phone: _____ Cell Phone: _____

Insurance Information:

Father / Mother / Self / Guardian (circle one)

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Employer: _____ Work Phone: _____

Employer Address: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Parent's Signature: _____ Date: _____



Student-Athlete Participant Liability Waiver Form

The undersigned, being the age of 18 years or older, hereby acknowledges that there are certain risks in participating in Collegiate Athletics. In consideration of the Community College of Rhode Island Department of Athletics allowing me to participate in Collegiate Athletics, I hereby assume all risks associated with any event and/or activity and with the travel related hereto. I assume full and complete responsibility for any injury or accident which may occur to me or the vehicle in which I am driving or riding in connection with the event and/or activity. I knowingly and intentionally hereby release and waive any and all claims, of whatsoever kind or nature that I may have against the Community College of Rhode Island, it's Board of Trustees, employees, agents and representatives, resulting in whole or in part, from participation in the event and/or activity. This release and waiver shall be binding on my heirs, administrators, and assigns.

I also agree that during the time I am involved with the Community College of Rhode Island Athletic Program, I am bound by all rules, regulations, policies, procedures and guidelines governing me and my conduct as set forth by the CCRI Department of Athletics and in Article IV: Proscribed Conduct found in the current CCRI Student Handbook.

Participant's Signature: _____ Date: _____

Full Name: _____

Student ID: _____

If the participant is under the age of 18 years, his/her parent or guardian must sign below.

Parent's/Guardian's Name: _____

Signature: _____ Date: _____

- PLEASE PRINT OR TYPE -



HIPAA - Notice of Privacy Practices

The Community College of Rhode Island uses and discloses health information about you. We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of this notice of privacy practices in effect. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact Mr. Steve Rooney, Assistant Director of Athletics / Sports Medicine / HIPAA Security Officer at 401-825-2405.

Treatment, Payment, Health Care Operations

CCRI Athletics creates and maintains health information for every student-athlete. This may include health history, diagnoses, symptoms, examination and test results, current treatment and any plans for future care or treatment. Protecting your privacy and keeping your medical and health information secure and confidential is one of our most important responsibilities.

CCRI Athletics are permitted to use and disclose your medical information:

- To any and all those involved in your treatment, including in the event of an emergency and you are not able to express yourself.
- To verify benefits, obtain authorization, bill claims and collect payment for the services provided to you,
- For the purposes of health care operations, which are activities that support this college and ensure the delivery of quality student-athlete care,
- If we receive a subpoena or similar legal process demanding release of any information required by law,
- For public health activities such as reporting a communicable disease or reporting an adverse reaction to the FDA,
- To report neglect, abuse or domestic violence,
- To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person,
- Deemed necessary by appropriate military command authorities if you are in the Armed Forces,
- In connection with certain types of organ donor programs.

We safeguard information during all business practices according to established security standards and procedures while continually assessing new technology for protecting information.

Requested Restrictions

You may request that we may restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We DO NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing to Mr. Steve Rooney, Assistant Director of Athletics / Sports Medicine / HIPAA Security Officer, Knight Campus, Warwick, Rhode Island:

- The information to be restricted,
- The kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both),
- To whom the limits apply.

Please note: We may change our policies and this notice at any time based on HIPAA law. Those revised policies will apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the CCRI Athletics Field House office bulletin boards.



Acknowledgement of Review of Notice of Privacy Practices

I have received and reviewed the CCRI Athletics Notice of Privacy Practices, which explains how my private health information will be used and disclosed. I understand that I am entitled to receive a copy of this document. By signing this form, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent. A photocopy or fax of this consent is as valid as the original.

In addition, I authorize the release of information to the individual/entities identified below by name and relationship:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Student-Athlete Name and Date

Signature Student-Athlete/Guardian

Student ID #

CCRI Athletics HIPAA Security Officer

For Office Use Only

We attempted to obtain written acknowledgement of review of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Other (Please specify) _____



Immunization Form for College Students

In accordance with the Rhode Island Department of Health's Rules and Regulations Pertaining to Immunizations and Testing for Communicable Diseases for Students Entering Colleges or Universities (R23-1-IMM/COL), the following student populations must complete and return this form.

- All incoming full-time students in any program of study must complete section A and have section B completed and signed by a licensed health care provider with the exception of high school records or VA records. Students in a health care field of study should refer to immunization forms provided by their department.
- NOTE: Titers are available through East Side Lab for a discounted rate. You must contact CCRI's Health Services nurse for a lab slip at 401-825-2103.

Part A: Personal Student Information:

Date: _____		CCRI ID*: _____	
Student's name: _____		Date of birth: _____	
Last, First, MI		MM/DD/YY	
Telephone number: _____		Email address: _____	
Program of study: _____		Part time <input type="checkbox"/>	Full time <input type="checkbox"/> Campus: _____

*A Social Security number also can be used but a CCRI ID is preferred. Don't know your CCRI ID number? It can be found printed on a bill or a class schedule, in your MYCCRI account, or by contacting Enrollment Services.

Part B: Immunization Information – All information is REQUIRED.

Please note that students carrying less than 12 credits do not need to submit this form.
Any student who cannot access childhood records can have titers done at a discounted rate.
Please contact the CCRI nurse for more information.

Was titer done?
Acceptable in place of
vaccine dates if unable
to obtain immunization
records.

MMR	1 st dose	MM/DD/YY	2 nd dose	MM/DD/YY			<input type="checkbox"/> Attach lab work
Hepatitis B	1 st dose	MM/DD/YY	2 nd dose	MM/DD/YY	3 rd dose	MM/DD/YY	<input type="checkbox"/> Attach lab work
Varicella (Chicken Pox)	1 st dose	MM/DD/YY	2 nd dose	MM/DD/YY			<input type="checkbox"/> Attach lab work
Tdap	Date:	MM/DD/YY					

Meningitis 1st dose MM/DD/YY Strongly recommended under age 22. 2nd dose MM/DD/YY If 1st dose given prior to age 16.

Health Care Provider signature _____ Date: _____

Telephone _____

Please return all forms to:
CCRI Health Services, Room 1240
Angela Marshall, RN
400 East Avenue
Warwick, RI 02886
(401) 825-2103
FAX (401) 825-1077
nurse@ccri.edu

Please note that if you have graduated from a Rhode Island high school within the past five years, you should be able to obtain a copy of your immunizations from that high school.



Accident Insurance Policy

The Athletic Department strives to provide the best possible conditions for competition, both on and off the playing field. A major component of that support is our sport medicine staff and our supplemental athletic accident and insurance coverage. Our sport medicine staff does an outstanding job in the caring of athletic injuries. However, there are times when athletic injuries require care beyond that provided by these professionals.

Consistent with other collegiate institutions, the Department of Athletics looks to your health and accident insurance as primary coverage. **CCRI must stress the Athletic department's coverage will be activated only after your personal insurance partially pays or declines to pay any bills.** Additionally, CCRI's excess coverage will only work if you complete the accompanying information form and return it to our athletic trainer. Below is a summary on the important aspects of our coverage.

1. Injuries sustained and reported by a CCRI student-athlete during official practice and games are evaluated by the sports medicine staff. After the initial evaluation, the student-athlete may then be referred to a specialist for further evaluation. If a student-athlete wishes to seek further medical attention, prior written approval must be obtained from the sports medicine staff. Unapproved consultations or treatments are not covered under our excess insurance.
2. Our excess coverage is an accident policy and **does not cover:**
 - a. An injury sustained in an activity, which is not associated with a supervised intercollegiate practice or competition during a sport season as defined by the NJCAA handbook.
 - b. **A chronic or recurrent injury which was sustained prior to or outside of participation in athletics at CCRI.**
 - c. Any degenerative or overuse problem as diagnosed by a physician.
3. **The essential first step: Complete the enclosed form advising the sports medicine staff of your personal health insurance carrier(s). To be covered under our insurance plan, the questionnaire must be completed, signed by a legal guardian and on file in the Athletic Trainer's office prior too sports participation. All subsequent changes in your coverage must be reported immediately.**

If you belong to a Health Maintenance Organization (HMO), you are limited to the HMO's physicians and facilities. The list should be available to you through your insurance company. Please send us specific instructions, requirements and/or limitations, which may be included in your policy. This information will provide us with the guidelines to follow in the event of an injury that requires medical attention.

Should an injury occur, the sports medicine staff would send the physician(s) the information regarding your insurance coverage. You should immediately send us your insurance company's resolution of claims (explanation of benefits) and all **itemized bills**. We will then file a claim with CCRI's excess insurance company, subject to its limitations and conditions, for payment of the remainder of the bill. If you don't have health insurance, it becomes a primary policy.

I have understood and agree to the above stated Accident Insurance Policy Statement. I understand the College's responsibility to the Student-Athletes participating in the Intercollegiate Athletic Program.

Student-Athlete Signature: _____ Date: _____

*Guardian Signature: _____ Date: _____

**Student Athlete under 18*

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / (/)	Pulse	Vision R 20/	L 20/
		Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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 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/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ 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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
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 exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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