

STUDENT-ATHLETE

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Date of Birth _____ Male Female Student ID # _____
Month/Day/Year

Mailing Address _____ Phone () _____
(Number, Street & Apt. # or P.O. Box #) (City) (State) (Zip)

Local Address _____ Cell () _____
(Number, Street & Apt. #) (City) (State) (Zip)

PARENT/GUARDIAN

Parent(s) Name _____ (Last) _____ (Father's First) _____ (Mother's First)

Home Address _____ Phone () _____
(Number, Street & Apt. # or P.O. Box #) (City) (State) (Zip)

INSURANCE INFORMATION

Are you covered by group or individual health and/or accident insurance? Yes No
If yes, please provide the following information:

Insurance Co. _____ Policy # _____

Subscriber's Name _____ Subscriber's Soc.Sec. # _____

EMERGENCY CONTACTS

Name _____ Phone () _____ Relationship _____

Name _____ Phone () _____ Relationship _____

FAMILY PHYSICIAN

Name _____ Phone () _____

SPORTS PROGRAM(S)

Please check ALL appropriate boxes for the sports in which you will be participating at this college:

- | | | | | |
|--|---------------------------------------|----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Field Hockey | <input type="checkbox"/> Hockey | <input type="checkbox"/> Soccer | <input type="checkbox"/> Track |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Football | <input type="checkbox"/> Rowing | <input type="checkbox"/> Softball | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Cross Country | <input type="checkbox"/> Golf | <input type="checkbox"/> Skating | <input type="checkbox"/> Swimming | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Diving | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Skiing | <input type="checkbox"/> Tennis | <input type="checkbox"/> Other _____ |

PLEASE CAREFULLY AND COMPLETELY READ THE FOLLOWING INFORMATION

Completion of this medical history and examination form is mandatory for participation in the sports programs of this college. Please make sure that all statements regarding your personal information and medical history is complete and accurate.

NWAC Regulations state: "After July 1st and prior to the first practice for participation in intercollegiate athletics, a student shall undergo a thorough medical examination and be approved for intercollegiate athletic competition by a medical authority licensed to perform a physical examination by the laws applicable in the state where the exam is conducted. Those licensed and approved to perform physical examination by the laws applicable in the state where the exam is conducted." Those licensed to perform physical examinations in the State of Washington include M.D., Doctor of Osteopathy (D.O.), Certified Registered Nurse (C.R.N.), Naturopath (N.D.) and Physician's Assistant (P.A.). The physical examination shall be valid for twenty-four (24) consecutive months to the date unless otherwise limited by the physician indicating the physical is only good for less than twenty-four (24) consecutive months.

This form is to be completed and signed by the student or, if the student is under the age of 18, by the student's parent or guardian. Any information withheld or falsified may affect the student's status on the athletic team and/or the student's scholarship funding. The college reserves the right, with the student's authorization, to request past medical records, charts and diagnoses regarding injuries, medical history or physical condition, and may request additional medical examinations or tests if indicated.

YOUR LAST PHYSICAL EXAMINATION

Date _____ Doctor's name _____ City, State _____

Please list any abnormalities found on any past physical examinations _____

IMMUNIZATION RECORD

Measles*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____
Mumps*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____
Rubella*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____
Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last dose	_____
Tetanus (Td)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____

*Note: These are commonly noted on immunization records as "MMR" and often given as one shot. A second dose of measles vaccine is recommended for college entrance.

FAMILY MEDICAL HISTORY

Please check YES or NO in appropriate box.

1. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	5. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia
2. <input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	6. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes
3. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuromuscular disease	7. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia
4. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Sudden death from heart disease or stroke	8. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer

If living, please check box to signify family member's general health. If deceased, please state age and cause of death, if known.

	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Deceased	Age at Death	Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

MEDICAL CONDITIONS & ILLNESSES

Have you ever had or do you now have any of the following medical conditions, illnesses or diseases?
Please check YES or NO for EACH item.

YES	NO		YES	NO		YES	NO	
9. <input type="checkbox"/>	<input type="checkbox"/>	Polio	26. <input type="checkbox"/>	<input type="checkbox"/>	Recurrent sinusitis	43. <input type="checkbox"/>	<input type="checkbox"/>	Hernia or rupture
10. <input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	27. <input type="checkbox"/>	<input type="checkbox"/>	Hearing loss/ear disease	44. <input type="checkbox"/>	<input type="checkbox"/>	Ulcers
11. <input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	28. <input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease	45. <input type="checkbox"/>	<input type="checkbox"/>	Testicular masses
12. <input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	29. <input type="checkbox"/>	<input type="checkbox"/>	Heart murmur/problems	46. <input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
13. <input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	30. <input type="checkbox"/>	<input type="checkbox"/>	Pericarditis	47. <input type="checkbox"/>	<input type="checkbox"/>	Bleeding disease
14. <input type="checkbox"/>	<input type="checkbox"/>	Collapsed lung	31. <input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	48. <input type="checkbox"/>	<input type="checkbox"/>	Anemia
15. <input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	32. <input type="checkbox"/>	<input type="checkbox"/>	Elevated cholesterol	49. <input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
16. <input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	33. <input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint problems	50. <input type="checkbox"/>	<input type="checkbox"/>	Asthma/hay fever
17. <input type="checkbox"/>	<input type="checkbox"/>	Diabetes	34. <input type="checkbox"/>	<input type="checkbox"/>	Bone infection	51. <input type="checkbox"/>	<input type="checkbox"/>	Skin disease/rash
18. <input type="checkbox"/>	<input type="checkbox"/>	Allergies	35. <input type="checkbox"/>	<input type="checkbox"/>	Chondromalacia	52. <input type="checkbox"/>	<input type="checkbox"/>	Measles
19. <input type="checkbox"/>	<input type="checkbox"/>	Tumors/Cancer	36. <input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	53. <input type="checkbox"/>	<input type="checkbox"/>	Mumps
20. <input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	37. <input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	54. <input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
21. <input type="checkbox"/>	<input type="checkbox"/>	Eye disease	38. <input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	55. <input type="checkbox"/>	<input type="checkbox"/>	Malaria
22. <input type="checkbox"/>	<input type="checkbox"/>	Color blindness	39. <input type="checkbox"/>	<input type="checkbox"/>	Goiter/thyroid disease	56. <input type="checkbox"/>	<input type="checkbox"/>	Car or air sickness
23. <input type="checkbox"/>	<input type="checkbox"/>	Near sightedness	40. <input type="checkbox"/>	<input type="checkbox"/>	Enlarged organs (spleen)	57. <input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown
24. <input type="checkbox"/>	<input type="checkbox"/>	Far sightedness	41. <input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder disease	58. <input type="checkbox"/>	<input type="checkbox"/>	Mental disorder
25. <input type="checkbox"/>	<input type="checkbox"/>	Nasal polyps	42. <input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal bleeding	59. <input type="checkbox"/>	<input type="checkbox"/>	Eating disorder

Student Name _____
(Last) (First) (Mid. Initial)

INJURIES & SYMPTOMS

Do currently have or have you ever had any of the following symptoms, problems or injuries?
Please check YES or NO for EACH item.

	YES	NO		YES	NO		YES	NO			
60.	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headache	71.	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or injury	82.	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
61.	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	72.	<input type="checkbox"/>	<input type="checkbox"/>	Back pain or injury	83.	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps
62.	<input type="checkbox"/>	<input type="checkbox"/>	Visual changes	73.	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain or injury	84.	<input type="checkbox"/>	<input type="checkbox"/>	Muscle wasting
63.	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain or injury	74.	<input type="checkbox"/>	<input type="checkbox"/>	Ankle pain or injury	85.	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea
64.	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	75.	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder dislocation/sep.	86.	<input type="checkbox"/>	<input type="checkbox"/>	Frequent vomiting
65.	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats	76.	<input type="checkbox"/>	<input type="checkbox"/>	Other joint sprain/disloc.	87.	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea
66.	<input type="checkbox"/>	<input type="checkbox"/>	Nasal fracture	77.	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain, at rest	88.	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal problems
67.	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	78.	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain, with exercise	89.	<input type="checkbox"/>	<input type="checkbox"/>	Internal injuries
68.	<input type="checkbox"/>	<input type="checkbox"/>	Breathing difficulty	79.	<input type="checkbox"/>	<input type="checkbox"/>	Joint weakness	90.	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding
69.	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent coughing	80.	<input type="checkbox"/>	<input type="checkbox"/>	Pinched nerve	91.	<input type="checkbox"/>	<input type="checkbox"/>	Unusual fatigue
70.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	81.	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion/stoke	92.	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping

GENERAL QUESTIONS

Please answer ALL of the following questions by checking either YES or NO for EACH item.

	YES	NO	
93.	<input type="checkbox"/>	<input type="checkbox"/>	Do you now have or have you ever had any chronic or recurrent illnesses?
94.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any illnesses lasting more than one week?
95.	<input type="checkbox"/>	<input type="checkbox"/>	If no to #93 or #94, do you now have or have you ever had any illnesses requiring treatment and care of a doctor?
96.	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear eyeglasses or contact lenses?
97.	<input type="checkbox"/>	<input type="checkbox"/>	Do you currently wear eyeglasses or contact lenses while participating in sports?
98.	<input type="checkbox"/>	<input type="checkbox"/>	Do you use any dental appliances such as braces, bridges or plates?
99.	<input type="checkbox"/>	<input type="checkbox"/>	Any body parts or organs missing (appendix, eye, kidney, testicles)?
100.	<input type="checkbox"/>	<input type="checkbox"/>	Are you now or have you ever been under the treatment of a medical doctor for any injuries?
101.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever fainted, passed out, been dizzy, knocked out, unconscious or had a concussion?
102.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a cast, splint, cane or crutches?
103.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an X-ray of any bone or joint?
104.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have to stop while running twice around a quarter-mile track?
105.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any trouble breathing, while at rest, <u>after</u> running one mile?
106.	<input type="checkbox"/>	<input type="checkbox"/>	Do you get any chest pain with exercise?
107.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any injuries or illnesses that caused you to miss a game or practice?
108.	<input type="checkbox"/>	<input type="checkbox"/>	Are there any reasons why you should not participate in sports?
109.	<input type="checkbox"/>	<input type="checkbox"/>	Have any of your close relatives, under the age of 50, died of heart problems or unexplained causes?
110.	<input type="checkbox"/>	<input type="checkbox"/>	Are you or any member of your family allergic to ANY medications (aspirin, penicillin, etc.)?
111.	<input type="checkbox"/>	<input type="checkbox"/>	Are you now taking or have you taken any medications, medicines, drugs or vitamins on a regular basis?
112.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any medical conditions that require special attention or treatment that the coach or athletic trainer should be aware of in the event of any injury or illness?

If you have answered "Yes" to any numbered item (1-112), please explain the situation or circumstances, including names of treating physicians and dates in the space provided. Identify each response by the number of the item in the left margin.

Item No.	Physician, City, State	Approx. Date	Explanation, including any surgeries you have had

Student Name _____
(Last) (First) (Mid. Initial)

Please list all previous fractures, concussions or other head injuries:

Item No.	Physician, City, State	Approx. Date	Injury

Please list all hospitalizations:

Item No.	Physician, City, State	Approx. Date	Reason for hospitalization, length of stay

Describe your current pattern of physical exercise

Activity	Frequency	Duration	Intensity

Describe the sickest you have ever been _____

Describe any weight changes over the last six months _____

List all medications -- prescription and/or over the counter -- drugs or vitamins that you currently take (including aspirin, birth control pills, etc.) _____

Describe any allergies -- from bites, drugs, foods, pollen, etc. -- you may have, including causes and reactions _____

At what age did you have your first menstrual period? _____ How many have you had during the last 12 months? _____

Date of last period _____ Describe any menstrual irregularity or discomfort _____

AGREEMENT OF UNDERSTANDING

I, the undersigned, certify that the above medical history is correct and true to the best of my knowledge, and that this student has no physical defects except as stated. This medical information is given with my permission and the medical examination is taken voluntarily. I further understand that any intentional omission of answers either verbally or in writing may result in disqualification from the community college sports program.

I authorize the release of this medical information, including the medical examination and the results of any medical tests, to the college for their use, evaluation and record keeping for this student-athlete's participation in the sports program of the college. I further authorize the release of this medical information, the medical examination and the results of any medical tests when deemed necessary by the college athletic coach, athletic trainer or other authorized college official; and I grant permission to any hospital, physician, surgeon, or other duly authorized medical personnel to release any other medical records, charts or diagnoses when deemed necessary for the treatment and care of this student-athlete in the event of injury or illness.

I further authorize and request the college's designated medical personnel to administer basic life support, advanced life support, and/or to obtain emergency medical care in the event of injury or illness at any specific emergency care facility so designated by the college physician or representative while participating in the sports program.

By my signature I verify that I have read, understand and agree to the above-stated conditions.

Student _____ Date _____

Parent/Guardian (If student is under 18 years of age) _____

Student Name _____
 (Last) (First) (Mid. Initial)

PHYSICAL EXAMINATION FOR SPORTS PARTICIPATION

To be completed by Licensed Medical Provider

To the Medical Provider: Please obtain and review the student's health history, pages one through four of this form, before conducting the examination. The intent of this exam is to focus on conditions of the athlete that may endanger his/her health, aggravate pre-existing conditions or increase the risk of death from participation in competitive college sports. If your findings or observations during this exam for sports participation indicate a need for a more comprehensive medical examination, you have the option of conducting a more comprehensive exam or advising the athletic director of the college in writing of the need for same. We appreciate your assistance and cooperation in maintaining the health of our student-athletes.

Student Name _____
 (Last) (First) (Middle Initial)

Date of Birth _____ Male Female Height _____ Weight _____
 Month/Day/Year

Blood pressure at rest and sitting: Left arm _____/_____ mmHG Right arm _____/_____ mmHG

Resting pulse rate: Apical _____ Radial _____

Visual acuity: Left 20/_____ Right 20/_____ Please check appropriate box: With correction Without correction

Please check appropriate box to indicate if Normal or ABnormal, and provide comments if abnormal.

SYSTEM		N	AB	COMMENTS
HEAD	Hair, scalp, masses, injuries			
EYES	Proptosis, conjunctivae, sclera, EOM, pupillary size, reaction to light, peripheral vision, fundi, gross tension to palpation			
EARS	Gross hearing to speech, drums, discharges			
NOSE	Septum, mucosa, sinuses			
THROAT/MOUTH	Teeth, tongue, tonsils, infections, lesions			
NECK	Thyroid, vessels, range of motion, adenopathy, masses, voice abnormalities			
THORAX/LUNGS	Shape, expansion, deformities, rhonchi, wheezes, rales			
HEART	PMI, sounds, thrills, murmurs, gallops, PVCs			
LYMPHATICS	Cervical, axillary			
ABDOMEN	Organ enlargement (liver, spleen, etc.), masses, tenderness, hernias, scars			
GENITALIA	Scrotum, testicles, lesions, discharge, hernias			
RECTAL (Optional)	Hemorrhoids, fissures, prostate, masses			
UPPER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
LOWER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
BACK	Flexion, extension, scoliosis, kyphosis, excessive lordosis, injuries			
NEUROLOGICAL	Cranial nerves, reflexes, motor, gait, balance, sensory			
SKIN	Texture, striae, rash, acne			
MENTAL STATUS	Affect, hostility, agitation			

LABORATORY TESTS (Optional or as indicated by examination)

Urinalysis: Sugar _____ Albumin _____ Ketones _____ Other _____

Hematology: Hematocrit _____

Summary of abnormal lab work _____

If medical history indicates the need for any vaccinations or booster shots, please administer during the physical examination.

Orthopedic Diagnoses _____

General Medical Diagnoses _____

Additional findings or comments on health history/significant injuries or illnesses _____

DISPOSITION (Please check one)

- Unrestricted activity in all sports
- No participation until _____ or until _____
(Date) (Conditions to be met)
- May participate, but with following limitations _____
- May not participate at all for following reasons _____

Medical Provider's signature _____ Date of Exam _____

MEDICAL PROVIDER IDENTIFICATION (Please print. Stamp or label okay)

Name _____ Phone (_____) _____
Address _____ City _____ Zip _____

Mail completed form to:
**CENTRALIA COLLEGE
SPORTS PROGRAMS OFFICE
600 Centralia College Blvd.
Centralia, WA 98531**

NOTE: The original of this report shall be confidentially filed and maintained in the athletic department. The information shall be readily available to health care providers in event of an emergency when intercollegiate sports are conducted, both at home and away from the college.

Student Name _____
(Last) (First) (Mid. Initial)