GRIZZLIES

BUTLER COMMUNITY COLLEGE

ATHLETIC PARTICIPATION INSURANCE & SPORT PHYSICAL INFORMATION BOOKLET

ATHLETICS
Dear Athlete and Parents/Guardians:

We would like to welcome you to our Grizzlies Athletics Family! We are already preparing for the upcoming school year. With the upcoming year approaching surprisingly quick, our staff would like to make you aware of the enclosed, important paperwork necessary for participating in our athletics programs.

The Sports Medicine staff believes in the importance of having a complete and thorough physical evaluation prior to competition. Beside the physical evaluation, is other paperwork such as insurance forms, etc. This ensures the athlete and care-givers a quality standard of care during your participation in Grizzlies athletics. In this packet you have been given the following forms:

- Sports Medicine Checklist
- Informed Consent & Release
- BCC Insurance information
- The Medical Policy and Procedures for Butler Community College
- Assumption of Risk Waivers
- Helmet Waiver (Football Only)
- Concussion Risk Acknowledge
- Insurance Information Form
- Student Athlete Family Information and Emergency Contact Form
- Health Information Release Form
- Medical History
- Pre-Participation Examination
- Drug Policy Packet

Each form is necessary for participation in athletics at the college. **PLEASE READ CAREFULLY AND FILL OUT FORMS IN PEN.** If you do not fill out all paperwork to the best of your ability, you will NOT be allowed to participate in the chosen sport until it is complete. This is for your safety and the school's as well. All authorization signatures must be complete. If you are under the age of 18, parental or guardian signature is necessary per form.

Athletic physicals are required on all athletes at the beginning of each school year. Each athlete needs to arrange for a physical to be completed by his or her physician before arriving at Butler Community College. If needed physicals will be available on campus through our team physician for a $20 fee. Physicals are active for one year beginning at the date the physical is performed.

Please complete all insurance information and sign below. Include a photo copy of your insurance card (front and back), any required claim forms, insurance company phone numbers and any other useful information that will help with the efficiency of claims. The information on the Primary Insurance Information form allows for direct billing to your insurance company for any bills incurred related to athletics. This is further explained in the Medical Policy and Procedures form. Grizzlies Athletic insurance policy is **secondary insurance ONLY** for athletic-related injury resulting from participation in or travel with Grizzlies Athletics. **The company will only pay remaining balances after the primary insurance has paid its share.**

Please return all completed information as soon as possible or have it with you when you report to campus. It is of utmost importance to understand that you shall NOT practice or compete until all forms are complete as instructed and are on file in the Sports Medicine office.

The Butler Grizzlies Athletic Department is looking forward to the upcoming school year, sport competition and working with you. Please do not hesitate to call us @ 316-322-3220 if you have any questions.
BUTLER COMMUNITY COLLEGE
SPORTS MEDICINE CHECKLIST

NAME: ___________________________  SPORT: ________________

Below is to be completed by the athletic training staff only.

1. ___ Informed Consent, Release and Indemnity.
2. ___ Assumption of Risk Waivers and Pre-Existing Injury Waiver.
3. ___ Athletic Trainer Authorization.
4. ___ Helmet Warning. (Football Only)
5. ___ Personal Insurance Information. Copy of Insurance Card. (Front AND Back)
6. ___ Emergency Contact Information.
7. ___ Disclosure Authorization.
8. ___ Medical History.
9. ___ Medical History and Pre-Participation Physical Examination.
10. ___ Drug Policy Packet.

___ Cleared to Participate.

___ Not Cleared to Participate.

Reason:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Athletic Trainer: ___________________________  Date: ________
Informed Consent, Release and Indemnity

I, ________________________, desire to participate in the Pre-Participation Physical Examination for Butler Community College. I acknowledge that the school provides structured competitive opportunities for men and women with varied interest and skill levels and that the intent of the physical is to provide a required evaluation for all who participate. With my signature below, I signify my acceptance of the Pre-Participation Physical Examination and understand that this physical is not a complete examination.

I understand this information will be used as an aide to provide necessary health care while I am a student-athlete. Information supplied will become part of my health record and will not be released to anyone, except Physicians, College trainers/staff, Appointed Coaching staff, Other Health Care Providers, Athletic administration and intercollegiate training/medical staff. Only general information about my sports injury may be reported to the press. I also understand that a more complete physical and evaluation are available at a higher cost. Such exams may include EKG, stress test, and chest x-ray and blood/urine tests.

I understand that every attempt is made to minimize the existing risks (that are inherent in the nature of some of the activities) through the use of proper sports equipment, safe facilities and sound safety practices. However, I also understand that these risks cannot be eliminated completely. I realize that as a sports participant, I could possibly incur injuries no matter how well-conditioned I may be. Due to the nature of sports, injuries may be minor to fatal in nature. Some specific injuries that are not common in sports, but possible are listed below:

A stoppage of breathing; spine and neck injuries (either of which could result in paralysis); heart failure; death; broken bones; heat stroke; heat exhaustion; stroke; bleeding; convulsions; unconsciousness; abrasions; fainting; sudden illness; cramps; and loss of wind. In addition, there is a potential for accidents or illness while traveling to and from competitive events.

The propensity for major injuries, such as broken bones, concussion and internal injuries to major organs increase in relation to the force of impact upon collision between two moving players. I understand that if I am participating in a collision sport, speed collisions will occur regularly, as an integral part of the sport.

These listed above are not intended to be inclusive of all injuries that may occur, but rather to inform me of the types of risks inherent in my participation in the athletic programs, so that I can make a voluntary choice to participate or not participate.

I also realize that the activity involved may be strenuous, and that the school has advised me to seek the advice of my physician before participating in this activity.

I hereby affirm that in consideration of the school's providing support for this program and allowing me to participate, I am voluntarily participating in any or all of the activities of the athletic program with full knowledge of the potential danger which they present, including bodily injury, property damage, and death,
and I hereby agree to accept any and all risk of such bodily injury, property damage, and death. I agree to inform trainers/doctors about any medication or supplements that I am taking, any surgeries or upcoming surgery, medical illness, or visit(s) to my doctor.

I agree to release and hold harmless the team physicians, athletic trainers and their agent, volunteers, officers and employees from liability for bodily injury, property damage or death arising from my participation in the Pre-Participation Physical Examination and sport participation. I give this release and indemnification in exchange for the opportunity for me to participate in the Pre-Participation Physical Examination and sport participation.

I certify that I have read this agreement, that it has been explained to me, and that I may be giving up legal rights I may otherwise have. I acknowledge that I am at least eighteen (18) years of age. If I am less than eighteen (18) years of age, my parent or guardian will sign with me.

Name (printed) ________________________________________________

Signature ___________________________________________ Date ________________

If under eighteen (18)

Parent/Guardian (printed) ____________________________________________

Signature ___________________________________________ Date ________________
Dear parents,

All athletes participating in intercollegiate athletics at Butler Community College (BCC) are covered under the school’s athletic insurance policy while participating in their team’s activities (practices, conditioning, travel, games, etc.). This policy functions as a **SECONDARY** insurance policy that goes into effect **AFTER** the student-athlete’s primary insurance has been filed and assessed. Butler Community College utilizes First Agency out of Kalamazoo, Michigan, as its insurance carrier. The following procedure outlines how the process works within our system.

1. All injuries must be reported to Amanda or Jared prior to seeing a physician. Only injuries occurring during team practice or competition will be covered under the secondary insurance.

2. The claim will be filed with the student-athlete’s primary insurance first. If the student-athlete does not have a primary insurance the secondary will act as such.

3. All medical bills and explanation of benefits (EOB) forms pertaining to the injury must be received at BCC Athletic Training Department or Department of Athletics.

4. Once those have been received the claim will be filed with First Agency.

**Please remember BCC cannot process any claims without the necessary medical bills and EOB’s. If you receive these at home, please make copies and send the originals to the BCC Athletic Department, in care of the Head Athletic Trainer.**
Butler Community College
Medical Policy, Procedures and Insurance Information Policy

Each student athlete is required to have a physical examination prior to participation in any intercollegiate sport. The final decision on physical qualification or reason for disqualification is the responsibility of the team physician and/or athletic trainer. The physician and/or athletic trainer also make the decision on when an athlete may return to competition after an injury.

All athletes are responsible for arranging and completing a physical from their home doctor. In the event you do not have a home doctor, physicals will be available on campus for a fee. When, for any reason, the physician recommends a specialist to be consulted before approval of sports participation, the individual concerned will be responsible for securing such information prior to any sport participation.

When previous injuries have been evaluated by a medical specialist prior to enrollment at Butler Community College, a letter of clearance must be submitted to the athletic trainer prior to participation in any sports activity.

Athletes may be disqualified from a particular sport program if the medical staff and consultants believe further participation would be hazardous to the health and safety of the athlete in question.

Accidents do occur and we attempt to provide our athletes with the very best possible care.

Medical bills may be incurred when the athlete is treated for bodily injury due to an accident, whether it is locally, during a road trip or by a medical vendor in his/her own home area.

The NCAA/NJCAA discourages any college or university from providing coverage or paying for expenses related to illness or conditions which are not sustained as the direct results of an accident in our intercollegiate sports program. This includes pre-existing conditions, non-athletic injuries and illness.

Claim Procedure

All medical bills for your son/daughter incurred as the result of an accident in the intercollegiate sports program will be sent directly to your son/daughter or to your home address, unless Butler Community College has instructed the vendors otherwise. In some cases, the athletic department may get a copy of the bill, but in no case will the athletic department be the primary place for the incurred bill to be sent.

Submit the bill incurred to your family or employer group coverage or plan first. One of two actions will occur:

A. The company will honor the claim and pay all or a portion of the bill incurred.
B. Not honor the claim and send you a letter of denial. An example might be that your son/daughter is no longer part of your group policy after attaining the age of 23.

If there remains a balance after your family or employer group insurance plan has contributed towards the claim, send: 1) the claim sheet (HICFA-FORM 1500), 2) the explanation of benefits (E.O.B.) and 3) a copy of the itemized bill to the college athletic department from your insurance company.
Insurance Coverage

The athletic accident insurance at Butler Community College provides coverage for your son/daughter while participating in the play of official team practice of intercollegiate sports, included sponsored and authorized team travel. However, this insurance is an excess policy. It is a secondary carrier to the student-athlete’s own coverage. It will pay only after his/her insurance company has paid or denied a claim.

**Butler Community College will **NOT** pay for medical services which have not been approved by the athletic trainer or the team physician.**
**PARENT/GUARDIAN/STUDENT INFORMATION FORM**

RETURN FORM WHEN COMPLETE TO: Name of College/University: Butler Community College

Attention: Athletic Office

Address: 901 S. Haverhill Road

City: El Dorado, State: KS, Zip: 67042

**Note:** Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete

Social Security No. or Passport No.

College Address

Home Address

City: State

**FATHER/GUARDIAN INFORMATION**

Father's Name

Social Security No.

Address

Employer

Address

Telephone (______)

Medical Insurance Company or Plan

Address

Policy Number

Telephone (______)

Is this plan an HMO or PPO? □ Yes □ No

Is pre-authorization required to obtain treatment? □ Yes □ No

**MOTHER/GUARDIAN INFORMATION**

Mother's Name

Social Security No.

Address

Employer

Address

Telephone (______)

Medical Insurance Company or Plan

Address

Policy Number

Telephone (______)

Is this plan an HMO or PPO? □ Yes □ No

Is pre-authorization required to obtain treatment? □ Yes □ No

Is a second opinion required before surgery? □ Yes □ No

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM
AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim or benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to; at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

[Signature]

Name of Authorized Representative, or Next of Kin (please print)

Name of Claimant (please print)

Date

Nature of Claimant (if claimant is 18 or older)

Signature of Authorized Representative or Next of Kin

Date

Relationship of Authorized Representative or Next of Kin to Claimant
Butler Community College Assumption of Risk Waivers

Section I:

While participating in the intercollegiate athletic programs and activities at Butler Community College students are afforded many different opportunities and benefits. Along with these advantages there are also inherent risks associated with both practice and competition. These injuries and dangers may lead to severe injury or death as a result of either practicing or competing voluntarily in intercollegiate athletics.

It is to be further understood that student athletes must share in the responsibility of their own safety and the safety of others as each participate in the intercollegiate athletic program. The student athlete should be aware that significant or debilitating injuries may be sustained in one or more of the following structures: muscle, tendon, ligament, bone, teeth, skin, genitalia, and any of the vital organs. The athlete should also be aware that catastrophic injuries, paralysis, and death may occur as a result of practice or participation in intercollegiate athletics. The student athlete should understand that there is no absolute prevention of the afore mentioned potential injury sites.

Section II: Acknowledgement of Risk

By signing below, I acknowledge that I have read the Assumption of Risk statement and that I am aware that there is a possibility that I may suffer mild, moderate, or severe injury, including paralysis or death due to participation in intercollegiate athletic activities. The student athlete should also acknowledge any injury incurred may cause life-long disability to joint, muscle, bone, ligament, tendon, or any of the vital organs.

I,________________________________________, the undersigned have read and I do accept the responsibility state above. Before I am approved for participation in practice or competition by the Butler Community College Sports Medicine department, I am required to sign below acknowledging the above statements.

_________________________________________ Date ____________

Student Athlete Signature

_________________________________________ Date ____________

Parent or Legal Guardian Signature (if athlete is under the age of 18)
Assumption of Risk Waiver Continued

Section III: Pre-Existing Injury Waiver

It must be understood that the Butler Community College Grizzlies Athletic Department, or college, will not be held responsible for injuries that have been determined by a medical doctor to be a pre-existing condition (that which was suffered prior to participating in either practice or competition for Butler Community College). Any required medical services for pre-existing conditions will be the sole responsibility of the athlete and his/her parent(s) or guardian.

I, ___________________________, have read and do accept the responsibility stated above. Before I am approved to participate in practice or competition by the Butler Community College Sports Medicine department, I am required to sign below acknowledging the above statements.

_________________________________________ Date ________________________

Student Athlete Signature

_________________________________________ Date ________________________

Parent or Guardian Signature (if student athlete is under the age of 18)

Section IV: Athletic Trainer Authorization

It must be understood that the Butler Community College Grizzlies Athletic Department, or college, will accept no responsibility for doctor visits or other medical services incurred by the athlete in which, there was no prior authorization from either the Head Athletic Trainer or Assistant Athletic Trainer. Any bills incurred by the athlete will be his/her sole responsibility for payment and arrangements of payment.

_________________________________________ Date ________________________

Student Athlete Signature

_________________________________________ Date ________________________

Parent or Legal Guardian Signature (if student athlete is under the age of 18)
Helmet Warning

Please read the following document thoroughly and sign at the bottom:

Upon my own initiative to participate in intercollegiate football at Butler Community College, I understand that there are inherent risks associated with the said sport. I have read and I understand the meaning of the following helmet warning attached to all helmets at Butler Community College.

Warning: DO NOT strike an opponent with any part of this helmet or face mask. This is a violation of football rules and may cause you to suffer severe brain or neck injury, including paralysis or death.

Severe brain or neck injury may also occur accidentally while playing football.

NO HELMET CAN PREVENT ALL SUCH INJURIES.

USE THIS HELMET AT YOUR OWN RISK.

I also understand that the above warning may still not prevent the occurrence of a severe, debilitating injury. The risk of physical impairment such as brain injury, or spinal trauma, etc. is assumed whenever one is involved in the sport of football.

I, ____________________________, do hereby declare that I have read the above statement and fully understand its meaning.

Signature: ____________________________ Date: ____________________

Signature of Parent (if under age 18): ____________________________
Student/Athlete acknowledgement and acceptance of responsibility concerning potential concussion.

I, ____________________________, understand that among the risks inherent in my athletic activities at Butler Community College; the possibility exists that a head injury and/or concussion may occur. By signing below, I accept these risks and further accept personal responsibility for reporting any signs or symptoms of a concussion to the athletic training and coach staff immediately if symptoms do occur. I also understand that upon my signing this statement I will receive educational information regarding concussion and head injury. This material provides opportunity for me to make informed decisions concerning my health status and provide health care professionals with information important for assuring appropriate medical treatment should it be needed.

Signs and symptoms of a possible concussion include the following:

- Persistent headache
- Headache that gets worse
- Drowsy or cannot be awakened
- Cannot recognize people or places
- Nausea and vomiting
- Unusual behavior or irritability
- Seizures
- Unusual weakness in limbs
- Numbness in extremities
- Slurred speech
- Balance problems
- Sleep disturbances
- Loss of appetite

Following a head injury and potential concussion it is better to be safe and conservation. Always consult a health care professional after a suspected concussion.

Signature __________________________ Date __________________________

Parent/Guardian Signature ____________________________________________ Date __________________________

(If under 18)
Butler Community College Insurance Information

IF you are covered by medical insurance, please fill out the following:

Primary Medical Insurance: ___________________________

Policy Holder’s Name: __________________________________

Policy Holder’s SS#: ___________________________________

Policy Number: _______________________________________

Group Number: _______________________________________

Insurance Company Address: ____________________________

City: ___________________ State: _______ Zip: _______

Phone Number: _______________________________________

Is pre-certification required? Yes ______ No ______

Is this athlete covered by any personal medical insurance? Yes ______ No ______

Is this athlete covered by any dental insurance? Yes ______ No ______

Is this athlete covered by any prescription coverage? Yes ______ No ______

COPY OF THE
FRONT
OF YOUR
INSURANCE CARD

COPY OF THE
BACK
OF YOUR
INSURANCE CARD

If you do not have primary health care insurance; Please read and complete the Statement of No Primary Health Insurance form.
Statement of **NO** primary health care insurance.

If you have no primary insurance this form must be filled out and notarized before you will be covered under the BCC Athletic Insurance company.

I, the undersigned state:

1) I do not currently own or am covered under any form of health/accident insurance health plan.

2) I understand and agree that any attempt to mislead or misinform Butler Community College may constitute insurance fraud.

3) I understand and agree to reimburse all parties if an inappropriate claim has been previously filed by Butler Community College.

Name: ___________________________ Date of Birth: _______________

SSN: ___________________________

Address: _________________________ State: _______ Zip Code ______

Signature: ________________________ Date: ______________________
Student Athlete Family Information and Emergency Contact Form

This form is to be filled out completely and will be used for insurance information and claims to Butler Community College's Secondary Insurance. **Failure to fill out this form correctly and completely may lead to delays in payment or rejection of payments.** This information will only be used for insurance claims or for Emergency contact purposes only.

Athlete’s Name: ____________________________________________

SSN# ___________________________ DOB: ______________________

Home Address: _______________________________________________________________________

City: __________________ State: _______ Zip Code: __________________

Cell Phone: __________________ Home Phone: ___________________

Parent/Guardian Home and work information

Father/Guardian’s Name: ____________________________________________

Home Address: _______________________________________________________________________

City: __________________ State: _______ Zip Code: __________________

Cell Phone: __________________ Home Phone: ___________________

Work Place: __________________

Address: __________________________________________________________________________

City: __________________ State: _______ Zip Code: __________________

Work Phone: __________________

Personal Insurance Company: ____________________________________________

Policy Number: ____________________________________________

If you do not work or have personal Insurance, please write **NOT APPLICABLE (N/A)** on the appropriate line.
Mother/Guardian’s Name: ____________________________________________

Home Address: ________________________________________________

City: __________________________ State: _______ Zip Code: ____________

Cell Phone: ____________________ Home Phone: __________________

Work Place: _________________________________________________

Address: ___________________________________________________

City: __________________________ State: _______ Zip Code: ____________

Work Phone: ________________________________________________

Personal Insurance Company: _________________________________

Policy Number: _____________________________________________

If you do not work or have personal insurance, please write NOT APPLICABLE (N/A) on the appropriate line.

Emergency contact if different than above stated people

Emergency contact’s Name: _______________________________________

Home Address: _______________________________________________

City: __________________________ State: _______ Zip Code: ____________

Cell Phone: ____________________ Home Phone: __________________

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Authorization for use and Disclosure of protected health information needed to assist in the determination of the status of a claim filed against the student accident insurance policy

I hereby authorize the use and disclosure of Protected Health Information to the individual(s) indicated below:

Information to use or disclose May include:

[X] Provider name, address & specialty (required) [X] Medical diagnosis
[X] Dates of service (required) [X] Services rendered
[X] Costs of services (required) [X] Medications
[X] Physicals [X] General Medical History

Persons or class of Persons to Whom Disclosure May Be Made:

[X] Certified Athletic Trainers [X] Coaches
[X] Doctors [] Media
[X] Student Health Center Staff [X] Dean of PE/Athletic
[X] Insurance Companies [X] Parent

I understand that this Authorization related to individually identifiable health information about me, which is called Protected Health Information as defined by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and,

That if the person or entity that receives this information is not a health plan, health care clearinghouse, or health care provider as defined in the Privacy Rule, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and That I may revoke the authorization at any time by notifying the BCC Athletic Training Staff in writing. However, if I choose to do so, my revocation will not affect any actions taken prior to my revocation; and,

That I may refuse to sign this authorization and that my refusal to sign in no way affects my sport participation. My refusal, however, may affect payment and may delay the processing of my claim.

Insured Student’s Name (print) __________________________________________

SSN: _______________________________ Date of Birth ____ / ____ / ____

Athlete’s Signature ______________________________________ Date ____ / ____ / ____

Parent/Guardian’s Signature ___________________________________ Date ____ / ____ / ____
(If a minor)
Butler Community College Grizzlies Athlete Medical History

Name: ___________________ Sport: ___________________

Date of Birth: ___________ Age: ___________ Social Security #: ___________

Gender: F or M ___________

Address: ___________________

City: ___________________ State: ______ State Zip Code: _____

Home number: ___________________

Cellular Phone number: ___________________

Please fill out this form completely being sure to read all questions thoroughly. Please be sure to explain, in detail, any questions that you answer with YES in the space provided for each section.

**Personal Medical History**

1. Do you suffer from frequent headaches? Y or N

2. Have you ever experienced vertigo or dizziness? Y or N

3. Have you ever experienced blurred vision or loss of sight? Y or N

4. Have you ever experienced sudden hearing loss? Y or N

5. Have you ever suffered a concussion? (Knocked out?) Y or N

6. Have you ever experienced a seizure or convulsions? Y or N

7. Have you been diagnosed with epilepsy? Y or N

8. Has a portion of your body ever become paralyzed or unable to move? Y or N

9. Have you ever passed out because you were too hot or had been told you had heat illness? Y or N

If you answered YES to any of the above questions please explain: __________________________

______________________________
10. Have you ever been hospitalized overnight? Y or N
11. Have you ever had a surgery? Y or N
12. Do you have a heart condition? Y or N
13. Do you have a disease affecting the valves of your heart? Y or N
14. Have you ever had an infection of the heart or tissues surrounding the heart? Y or N
15. Do you have a heart murmur? Y or N
16. Have you been told by a physician you have high blood pressure? Y or N
17. Have you ever been diagnosed as anemic? Y or N
18. Have you ever had mononucleosis? Y or N

If you answered YES to any of the above questions please explain:

_____________________________________________________________________________

_____________________________________________________________________________

IF YOU HAVE HAD SURGERY WITHIN THE LAST 12 MONTHS YOU NEED TO PROVIDE A MEDICAL RELEASE FROM YOUR SURGEON.

19. Do you have any allergies? Y or N
20. Are you allergic to any medications that you are aware of? Y or N
21. Have you been diagnosed with asthma? Or have you had a history of asthma? Y or N
22. Have you ever been told you have any conditions that would exclude you from competitive Athletics? Y or N
23. Have you been diagnosed with diabetes? Type I or Type II Y or N
24. Have you lost or gained more than 5 pounds recently? Y or N
25. Have you ever taken weight gaining or training supplements? Y or N
26. Have you ever taken, or are presently taking, ergogenic aids? Y or N
27. Have you ever taken, or are presently taking, ephedrine? Y or N
28. Have you ever taken, or are presently taking, vitamin supplements? Y or N
If you answered YES to any of the above questions, please explain:

29. Have you ever vomited blood?  
   Y or N

30. Have you ever had an enlarged spleen or liver?  
    Y or N

31. Have any of your bowel movements ever been dark black or bloody?  
   Y or N

32. Have you ever urinated blood?  
    Y or N

33. Have any of your bowel movements ever been painful?  
    Y or N

34. Have you ever had a kidney infection?  
    Y or N

35. Have you ever had a hernia?  
    Y or N

36. Have you ever had an eating disorder?  
    Y or N

37. Have you ever been diagnosed with depression?  
    Y or N

38. Have you ever been diagnosed with a mental disorder?  
    Y or N

If you answered YES to any of the above questions please explain:

Females:

39. When was the date of your last menstrual cycle?  

40. Are your periods regular and on time?  
   Y or N

41. Do you have extreme pain or bleeding associated with your period?  
   Y or N

42. Have you ever been diagnosed with amenorrhea?  
    Y or N

43. Have you ever been diagnosed with endometriosis?  
    Y or N

44. Have you ever been diagnosed with osteopenia or osteoporosis?  
    Y or N

Males:

45. Do you have only one testicle?  
   Y or N

46. Have you ever had any lump to your scrotum?  
    Y or N

47. Have you ever had an injury to your scrotum?  
    Y or N

48. Have you ever been diagnosed with, or treated for, testicular cancer?  
    Y or N
If you answered YES to any of the above questions please explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

48. Do you have only one eye? Y or N

49. Do you wear contacts or glasses? Y or N

50. Do you have any false teeth or bridges? Y or N

51. Do you, or have you in the past, have frequent nosebleeds? Y or N

52. Do you have a history of gum disease or dental caries? Y or N

53. Please list ANY current medications, prescriptions, and/or supplements you are currently taking.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

54. Have you ever injured, sprained, broken, or had swelling to the head and neck? Y or N

If yes, please explain:________________________________________________________________________

________________________________________________________________________

55. Have you ever injured, sprained, broken, or had swelling to the shoulders? Y or N

If yes, please explain:________________________________________________________________________

________________________________________________________________________

56. Have you ever injured, sprained, broken, or had swelling to the elbow, or arm? Y or N

If yes, please explain:________________________________________________________________________

________________________________________________________________________

57. Have you ever injured, sprained, broken, or had swelling to the wrist and/or fingers? Y or N

If yes, please explain:________________________________________________________________________

________________________________________________________________________

58. Have you ever injured, sprained, broken, or had swelling to the back? Y or N

If yes, please explain:________________________________________________________________________
59. Have you ever injured, sprained, broken, or had swelling to the pelvis or hips?  
   Y or N
   If yes, please explain: ____________________________________________

60. Have you ever injured, sprained, broken, or had swelling to the knee?  
   Y or N
   If yes, please explain: ____________________________________________

61. Have you ever injured, sprained, broken, or had swelling to the ankle or foot?  
   Y or N
   If yes, please explain: ____________________________________________

62. Have you ever dislocated a joint?  
   Y or N
   If yes, please explain: ____________________________________________

63. Have you ever experienced back pain or low back pain?  
   Y or N
   If yes, please explain: ____________________________________________

Family History

64. Does anyone in your immediate family have frequent headaches?  
   Y or N
   Who? ____________________________________________

65. Does anyone in your immediate family have Type I or Type II diabetes?  
   Y or N
   Who? ____________________________________________

66. Does anyone in your immediate family have heart disease?  
   Y or N
   Who? ____________________________________________

67. Does anyone in your immediate family have high blood pressure?  
   Y or N
   Who? ____________________________________________

68. Does anyone in your immediate family have cancer?  
   Y or N
   Who and what type? ____________________________________________
69. Does anyone in your immediate family have an enlarged heart? Y or N
   Who? __________________________________________

70. Are there any other diseases or conditions that there is an immediate family history of? Y or N
   Please explain:
   ______________________________________________________
   ______________________________________________________

I certify that all of the above questions and statements are answered to the best of my knowledge.

_________________________________________ Date __________________
Student Athlete Signature

_________________________________________ Date __________________
Parent or Legal Guardian

(If athlete is under the age of 18)
BCC General Orthopedic and Physical Examination

Name: ___________________________ Age: ______ DOB: __________

BCC Phone #: ____________________ Social Security #: ________________

Vital Signs:

Weight: ______ Height: ______ BP: ____/____ Pulse: ______

ORTHOPEDIC EXAMINATION

<table>
<thead>
<tr>
<th>WNL</th>
<th>BODY PART</th>
<th>EXPLAIN PROBLEM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Head and Neck</td>
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<tr>
<td></td>
<td>Shoulders</td>
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<td></td>
<td>Elbows</td>
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<td></td>
<td>Wrist and Hands</td>
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<td></td>
<td>Spine</td>
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<td></td>
<td>Hips</td>
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<td>Ankle</td>
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<td></td>
<td>Feet</td>
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</tbody>
</table>

GENERAL EXAMINATION

<table>
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<th>EXAMINATION</th>
<th>EXPLAIN PROBLEM</th>
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<tbody>
<tr>
<td></td>
<td>General Appearance</td>
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<tr>
<td></td>
<td>HEENT</td>
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<tr>
<td></td>
<td>Chest-Lungs</td>
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<td></td>
<td>CV</td>
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<td></td>
<td>Abdomen</td>
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<tr>
<td></td>
<td>Neurological</td>
<td></td>
</tr>
</tbody>
</table>

______ CLEARED FOR COMPETION.

______ Cleared after complete evaluation/rehabilitation. (See back sheet)

______ NOT CLEARED FOR COMPETION. (See back Sheet)

Name of Physician (print/type): __________________________

Signature of Physician: ___________________________ Date: __________
BCC General Orthopedic and Physical Examination

Cleared after completion of evaluation/rehabilitation for:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

NOT CLEARED FOR COMPETITION DUE TO:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name of Physician (print/type):__________________________________________

Signature of Physician:__________________________________________ Date:_______________

IF YOU HAVE HAD SURGERY WITHIN THE LAST 12 MONTHS YOU NEED TO PROVIDE A MEDICAL RELEASE FROM YOUR SURGEON.