Dear Parent/Guardian and Student-Athlete,

This is a blanket letter to the parents of all student-athletes who plan on participating in an intercollegiate sport. The purpose of this letter is to inform you about Athletic Training Services and the sports medicine care available to your athlete at Iowa Central Community College.

The purpose of the athletic training staff is to maintain a balance between a competitive edge in a sport and ensuring participant safety. Our primary concern is the health of the student-athlete. We manage this objective through early and accurate recognition of athletic injuries and supervision of a complete rehabilitation plan. In order for us to achieve these goals your understanding of our responsibilities and our program is essential.

**Items Needed Before Coming to Campus**

There is a list of things that need to be done before your athlete makes their way to campus for the school year. The most important is a physical exam that can be found on the Inside Athletics page at [http://www.ictritons.com/inside_athletics/athletic_forms.asp](http://www.ictritons.com/inside_athletics/athletic_forms.asp) Also on that page is a Parent information sheet that gives us information on primary insurance that your student-athlete has. The school has a secondary insurance policy that may cover any expenses that are not covered by primary insurance of an athletic related injury only *(not general illness)*. Also prior to coming to campus we will need a copy of the primary insurance card for the athlete. There are also other forms on the page that need to be completed, the medical waivers, and then completing ATS.

If you do not have primary insurance coverage for your student-athlete they are able to purchase insurance through the school and the cost of that insurance will go on their school bill, it is required that all athletes have insurance the entire time that they are at school.

International students are required to purchase insurance from the carrier that we have set up. The reasoning for that is so that we can insure that there is athletic accident coverage, and an insurance our local providers accept.

Once we have all of the information that is needed for your son/daughter to participate in their sport they will be given a water bottle free of charge; however; if they lose the first bottle they will be required to purchase the second bottle from us or provider their own bottle.

- Physical
- Insurance card copy (both front and back side)
- Parental Information Sheet
- Waiver Packet
- ATS online paper work
Athletic Training Services
We work in three main areas, the prevention, management, and rehabilitation of athletic injuries. I have attached a more complete list of the services we provide. I have also attached information on our educational background and qualifications.

We provide medical coverage to all scheduled competitions and practices. This is provided through our student staff that are certified and trained in CPR and First Aid. All scheduled home games are covered by at least one certified athletic trainer. During games the certified athletic trainer is responsible for all medical decisions.

We have a very structured and complete system of sports medicine care at Iowa Central. We are extensively involved. We do not expect you or your daughter/son to make sports medicine decisions on your own. That is our primary function at the college, and we are happy to assist you. We are here to manage athletic injuries from start to finish.

Physician Referrals
Our general rule is, in all non-emergency situations no one should see a physician without seeing us first. For the best results we want all referral decisions coordinated through us. This allows several important things to happen. It ensures all relevant parties are aware of the injury. It ensures we have a precise diagnosis, treatment plan, and participation status from the physician before the student-athlete returns to play. In short it allows us to provide optimum care before, during and after the physician visit.

If you feel your son or daughter needs to see a physician for an injury, please feel free to give us a call and discuss the situation. In every case I will explain our rationale and we can always come to a mutual decision.

Insurance claims for this policy are filed through Athletic Training Services. If the athlete is seen by us before seeing a physician we will assist in coordinating the paperwork for coverage by our insurance carrier (i.e., the collection of bills, explanation of benefits, etc.). If the athlete does not inform us before seeing a physician, then there will be no claim on file and no bills will be paid by our secondary carrier.

Talk to Us
We invite you to contact us if you have any questions about this letter or at any time during the year. In order for us to do our job we need to be informed about injuries. We ask for your complete cooperation following the guidelines above. Should your son/daughter inform you about an injury or problem please make sure that they also inform us. There are times when they do not. Or in this situation, feel free to call us and we will approach your son/daughter about their injury to ensure their care is optimal.

Sincerely,

Iowa Central Athletic Training Staff
Iowa Central Community College
Participant in Intercollegiate Athletics
Assumption of Risk, Release and Waiver of Liability, Indemnification
and Hold Harmless Agreement

Please read the following language carefully: (If you are less than 18 years of age, your parent or
guardian must also read and sign this Agreement).

In consideration of being permitted to participate in intercollegiate athletics at Iowa Central Community
College, I, the undersigned, hereby agree as follows:

• Assumption of Risk.

I hereby acknowledge and understand the possibility of sustaining a catastrophic injury is inherent in
intercollegiate athletics and understand that by participating in intercollegiate athletics at Iowa
Central Community College the potential of sustaining a catastrophic injury is possible, including
but not limited to a serious neck and spinal injuries which may result in complete or partial paralysis,
brain damage, serious injury to internal organs, serious injury involving bones, joints, ligaments,
muscles, tendons, and other aspects of my body, and death. I understand that the dangers and risks of
participating in intercollegiate athletics may result not only in serious injury, but in a serious
impairment of my future abilities to earn a living, to engage in other business, social and recreational
activities, and generally to enjoy life; and I knowingly and voluntarily accept and assume
responsibility for such risks and dangers that could arise out of, or occur during, my participation in
intercollegiate athletics at Iowa Central Community College, even if such risks and dangers arise in
whole or in part from negligence of Iowa Central Community College and or its employees, agents,
and representatives.

With this in mind, I recognize the importance of rules and procedures as well as the necessity of
using proper techniques and following instructions from coaches, assistance coaches, and athletic
trainers.

• Release and Waiver of Liability.

I hereby warrant that I am qualified, in good health, and in proper physical condition to participate in
intercollegiate athletics at Iowa Central Community College. I hereby release and forever discharge
Iowa Central Community College and its past, present, and future officers, directors, administrators,
coaches, athletic trainers, all other employees, agents, assigns, representatives, attorneys, affiliates
and insurers from any and all liability, loss, damages, costs, claims and or causes of actions resulting
from any accident, illness, bodily harm, personal injury, death, and or property loss, however caused,
from or in any way related to my participation in intercollegiate athletics at Iowa Central Community
College including losses caused in whole or in part by the negligence of Iowa Central Community
College and or its employees, agents, and representatives.

Further, and to the same extent and scope, I hereby release and forever discharge Iowa Central
Community College and its past, present, and future officers, directors, administrators, coaches,
athletic trainers, all other employees, agents, assigns, representatives, attorneys, affiliates and
insurers from any claim whatsoever that may be attributable to the receipt of preventative, first-aid,
emergency, rehabilitative, and other medical care to treat injuries I sustain as the result of or during
Iowa Central Community College intercollegiate athletic activities.

• Indemnification and Hold Harmless.


I hereby agree to indemnify and hold harmless Iowa Central Community College and its past, present, and future officers, directors, administrators, coaches, athletic trainers, all other employees, agents, assigns, representatives, attorneys, affiliates and insurers from any and all claims, demands, lawsuits, liabilities, damages, expenses (including reasonable attorney fees), and or costs arising out of or related to my participation in intercollegiate athletics at Iowa Central Community College.

I have read and fully understand the terms of this Assumption of Risk, Release and Waiver of Liability, Indemnification and Hold Harmless Agreement. I understand the legal significance of this Agreement and I agree to the terms of this Agreement.

I, the undersigned, affirmatively state that I am at the time of this signing of legal age (or if not of legal age will have an appropriate parent or guardian sign as well) and fully competent to and do hereby voluntarily and without inducement from any party execute this Assumption of Risk, Release and Waiver of Liability, Indemnification and Hold Harmless Agreement on behalf of myself, my heirs, or assigns.

The undersigned understand that an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Student’s Signature: ________________________________ Date: ______________
Sport(s): ______________________________________
Print Name: ____________________________________
If under 18 years of age,
Parent/Guardian Signature: ________________________ Date: ______________
Iowa Central Community College
Participant in Intercollegiate Athletics
Authorization and Consent for Medical Treatment and Care
and
Release of Medical Information and Records

Please read the following language carefully: (if you are less than 18 years of age, your parent or guardian must also read and sign this Agreement).

I, the undersigned:

- authorize Iowa Central Community College athletic training staff, team physician, and or medical consultant(s) to evaluate and provide me with preventative, first-aid, emergency, rehabilitative, and other medical care to treat injuries I sustain as the result of or during Iowa Central Community College intercollegiate athletic activities;

- understand that the team physician has the authority to prohibit me from participating in intercollegiate athletics at Iowa Central Community College because of an injury and or because of undue risk of liability to myself or others;

- give permission for medical information and or records to be released and discussed with Iowa Central Community College athletic training staff, team physician, and or medical consultant(s), and my parents and/or guardians; and

- if reasonably necessary to provide the care described above, grant permission to Iowa Central Community Intercollegiate Athletic Director or his or her designee or Head Coach to authorize my admission to a hospital or facility that provides said care and or treatment.

In providing this authorization and permission, I understand and agree that payment of the cost of providing medical and hospitalization, care and or treatment, including but not limited to surgery, will be my responsibility and that while I am an intercollegiate athlete at Iowa Central Community College I will maintain in effect major medical and hospitalization insurance for myself that includes coverage for such medical and hospitalization, care and or treatment, including but not limited to surgery. I understand that any medical and hospitalization insurance provided by Iowa Central Community College through First Agency, Inc. is solely secondary insurance coverage and is not primary insurance coverage.

I have read and fully understand the above authorization and consent for medical treatment and care and release of medical information and records and I agree. The undersigned understand that an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Student’s Signature: __________________________________________ Date: ____________

Sport(s): ________________________________ Date: ____________

Print Name: ____________________________________________________________________

If under 18 years of age, Parent/Guardian Signature: ________________________________ Date: ____________
Iowa Central Community College
Participant in Intercollegiate Athletic
Authorization (HIPPA Form) - To Permit Use and Disclosure of Health Information to First Agency, Inc. and to Iowa Central Community College

Authorization - To Permit Use and Disclosure of Health Information.

This Authorization is for the purpose of First Agency, Inc. obtaining information necessary to process a claim for benefits.

This Authorization is also for the purpose of Iowa Central Community College obtaining health information to determine appropriate participation in intercollegiate athletics by the student athlete.

Upon the 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, and to provide to the Iowa Central Community College Intercollegiate Athletic Director all information concerning advice, care or treatment provided to the patient, student, 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 First Agency, Inc.'s health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to:

First Agency, Inc., to the attention of the Claims Supervisor my agent or to us at the following address:

and

the Iowa Central Community College Intercollegiate Athletic Director of One Triton Circle, Fort Dodge, IA 50501.

I understand that a revocation will not be effective to the extent First Agency, Inc. and or Iowa Central Community College have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

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 that once information is disclosed to First Agency, Inc. and to Iowa Central Community College Intercollegiate Athletic Director pursuant to this Authorization, the information will remain protected by First Agency, Inc. and by Iowa Central Community College in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request. This Authorization is valid from the date signed below.

I, the undersigned, understand that an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Name of Student Athlete: ____________________________
Signature of Student Athlete: ____________________________ Date: ________________
Iowa Central Community College
Drug Testing Policy for Participants in Intercollegiate Athletics

In consideration of being permitted to participate in intercollegiate athletics at Iowa Central Community College, as a student athlete I agree to comply with all the regulations of Iowa Central Community College, its Department of Athletics, and its affiliated organizations and programs, including the Department of Athletics' Alcohol, Substance Abuse and Drug Screening /Testing Policies and Procedures. As a student athlete at Iowa Central Community College, I acknowledge and agree that:

- I have read and agree to comply with the attached Department of Athletics' Alcohol, Substance Abuse and Drug Screening /Testing Policies and Procedures;
- I may be subject to random alcohol and drug testing and or reasonable suspicion alcohol and drug testing as determined by and at the discretion of the Intercollegiate Athletic Director by the use of a urine or saliva sample;
- I may be temporarily or permanently suspended from a team or there may be a recommendation made for non-renewal of my scholarship, if applicable, for violation of the alcohol and substance abuse policy, competitive rules, or other Iowa Central Community College policy,
- If it is determined by the Intercollegiate Athletic Director that counseling, rehabilitation, substance abuse education or other such services are to be part of the conditions arising from a confirmed positive test result, any expenses incurred for counseling, rehabilitation, substance abuse education or other such services are will be my sole responsibility; and
- The drugs TO BE TESTED for include prohibited drugs on the NCAA Band Drug Reference List and including but not limited to the following: ALCOHOL, AMPHETAMINES, COCAINE, MARIJUANA, PCP, OPIATES, PHENCYCLIDINE, METHAQUALONE, BARBITURATES, BENZOPAIN, PROPOXYPHENE, METHADONE and ANABOLIC STEROIDS.

I understand that my signature below signifies that I have read and understand the above and agree as stated above.

I, the undersigned, understand that by typing my name in the provided box an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Signature of Student Athlete: __________________ Date: ___________
Iowa Central Community College
Department of Athletics
Alcohol, Substance Abuse and Drug Screening/Testing Policies and Procedures

I. Introduction:
The Department of Athletics at Iowa Central Community College recognizes that drug use is a matter of deep concern in our society. The use of prohibited drugs, alcohol, and the abuse of drugs and alcohol and other controlled substances, as well as chemical dependency to such agents, constitute a threat to the integrity of intercollegiate athletics and represents a danger to the health, welfare and career of the ICC student-athletes. The main purpose of this policy is to protect the Iowa Central Community College student-athletes from the risks and dangers of alcohol and drug abuse through such measures as drug and alcohol education, drug testing, drug counseling and rehabilitation, and when appropriate, sanctions.

II. Objectives:
The Department of Intercollegiate Athletics has established the following Alcohol and Drug Policy and Program objectives:

1. Provide an alcohol and drug free environment.

2. Educate student-athletes, coaches, and staff members about the physical, social, psychological, financial, and legal problems associated with alcohol abuse and drug use.

3. Identify student-athletes who are abusing alcohol or drugs and assure prompt counseling and treatment.

4. Provide a program to assist individuals who use or abuse drugs or alcohol to recognize their problem and be referred for counseling and rehabilitation.

5. Provide a fair administrative process for sanctions and appeals.

III. Application of Policy:
All student athletes found in violation pertaining to drug abuse and testing will be subject to sanctions accumulating from the first violation.

IV. Drug Testing
Any prohibited drug on the NCAA Banned Drug Reference List (hereinafter “NCAA”) and any subsequent additions to the original list, regardless of whether such drugs are prescribed or non-prescribed, legal, or illegal, and any other controlled dangerous substance may be tested. Included are “street drugs” (as defined by NCAA guidelines). As a condition of participation in ICC’s athletic programs each student-athlete shall be required to sign a release/consent form (prior to the start of each year of athletic participation), which states that he/she is aware that urine testing for the presence of drugs is permitted by the ICC Athletic Department and participation in the drug testing program is mandatory. Once the policy is signed by the student-athlete, the student-athlete thereafter will be subjected to unannounced, observed and/or unobserved, random drug testing for the presence of any prohibited drug. The determination of which student-athlete will be tested and the frequency of testing in response to an individualized reasonable suspicion shall be at the discretion of the Athletic Director. In signing the release/consent form, each athlete understands that failure to undergo testing will result in sanctions pertaining to a first violation (positive test). Failure to undergo testing a second time will
result in sanctions pertaining to a second violation (positive test). Failure to undergo testing a third time will result in sanctions pertaining to a third violation (positive test).

The results of the testing, by the certified laboratory, will be reported to the Athletic Director. The parent-guardian, team physician, sport head coach, and other university officials may receive the results, if it is deemed appropriate by the Athletic Director.

V. Drug Testing Sanctions:

A. Violation (Positive Test):
   1. The President, Athletic Director, Head Athletic Trainer, Sport Head Coach, and if the student is a minor, Parents/Guardians may be informed of the positive results unless a valid subpoena or court order is obtained.
   2. The student-athlete will be required to follow the code of conduct policies set forth by the head coach of the sport which they participate and the athletic department.

VI. Probable Cause

Student-athletes will be drug-screened and/or evaluated if there is probable cause to suspect alcohol, drug use, or abuse. The coaching staff, athletic training staff, or athletic director may be aware of or see certain signs, symptoms or changes in behavior that may cause them to suspect substance abuse. These staff members have a duty to report any suspicions to the Sport Head Coach, Athletic Director, or Head Athletic Trainer. A decision will be made regarding the need for counseling and/or testing.

Such behaviors may include, but are not limited to the following signs, symptoms and behaviors:

1. Student-Athlete begins to show:
   • Poor motivation
   • Sloppy hygiene and appearance
   • Lack of hustle on the field or court
   • Irritability or loss of temper
   • Failure to follow orders or lack of discipline
   • Unexplained absences
   • Common and routine injuries which will not heal or which are recurrent

2. Has recurrent problems with:
   • Being late to practice, team meetings, or functions
   • Missing appointments
   • Ignoring curfews
   • Staying up too late
   • Falling asleep during day
   • Skipping meals

3. Appearance of the following signs and/or evidence of illness
   • Dilated or constricted pupils
   • Droopy eyelid or reddish eyes
   • Excessive scratching and breaking out of skin
   • Constantly runny, red nose
• Recurrent bouts of flu or colds that require medical attention
• Appears over-stimulated or “hyper”
• Becomes withdrawn and less communicative
• Repeated automobile and traffic violations

VII. Review/Appeal Process
If a student-athlete tests positive for a banned substance, he/she has the right to a review. The Athletic Director must receive a written request for a review within 48 hours of the notification of the positive test.

If the student-athlete wishes to appeal the methods of evaluation and treatment imposed, he/she must request a hearing before the Appeals Committee within 48 hours of being notified of a positive screen. The burden of proof is on the student-athlete to show any extenuating circumstances as to why the Department of Intercollegiate Athletics’ evaluation and treatment program is not appropriate.

If the student-athlete wishes to appeal a disciplinary decision or sanction, the Athletic Director must receive the written request for appeal within 72 hours of the student-athlete’s notification of the penalty.

The Athletic Director will notify the Appeals Committee of the appeal request. A hearing will be arranged within five (5) working days following the request by the student-athlete.

APPEALS COMMITTEE:
1. An Athletic Department administrator (one of the following serves as chairperson: Athletic Director, Senior Women’s Administrator, or Faculty Athletics Representative)
2. An uninvolved Coach
3. A representative of the University’s Legal Counsel
4. A member of the full-time Athletic Training Staff
5. Vice President for Student Affairs or Representative

VIII. TESTING PROCEDURE
1. The student-athlete accompanies the Athletic Trainer and one witness from the Iowa Central Community College athletic department into the restroom.
2. The student-athlete is then given directions on the testing procedure, and asked to remove baggy clothing (i.e. Sweatshirt, jacket, ect.).
3. The athlete will then go into the stall and retrieve the sample.
4. The student-athlete will place the sample on the ledge in the bathroom.
5. They will be shown the test panel packet to confirm it is still sealed, and then when the package is opened they will be shown that it is blank.
6. The panel will then be dipped into sample for 10 seconds and placed to rest for 5 minutes; the results will then be reviewed with the athlete.
7. If the test is positive the athlete will fill out the required paperwork and then watch as sample is packaged and sealed then the student-athlete will initial the bottle.

DRUG USE MAY AFFECT ATHLETIC PERFORMANCE

DRUG: COCAINE
EFFECT:
• Over-stimulates reflexes
• Distorts vision
• Hurries muscle movement
• Weakens breathing
• Long-term use weakens muscles and nerves and makes them prone to injuries
• Alters normal appetite

**DRUG: MARIJUANA**
**EFFECT:**
• Slows reflexes
• Long-term use weakens muscles and nerves and makes them prone to injuries
• Slow or non-reactive pupil distorts vision
• Hearing impairments

**DRUG: AMPHETAMINES**
**EFFECT:**
• Over-stimulates reflexes
• Distorts vision
• Alters normal appetite

**DRUG: ALCOHOL**
**EFFECT:**
• Reduces mental alertness for approximately 24 hours after a binge or about three beers or drinks

**HOW MARIJUANA AND COCAINE CAN CAUSE ATHLETIC INJURIES**
• Depletes energy
• Impairs visual perception
• Alters normal reflexes
• Drives out chemicals at nerve-endings
• Decreases immune and inflammatory mechanisms necessary for healing (i.e. routine simple injuries do not heal rapidly)
• Collects in fatty tissues around muscles, tendons, and ligaments (i.e. marijuana)
• Worsens normal simple injuries

**ANABOLIC STEROIDS**
This class of drug is a derivative of the male hormone testosterone. Testosterone will increase protein synthesis, when coupled with training and proper diet, may create an increase in lean muscle mass. Being a hormone, the anabolic steroid will interfere with the normal hypothalamic-pituitary-gonad thermostat and disturb the body’s delicate hormone balance. This interference can produce detrimental side effects. Anabolic Steroids are banned by the N.C.A.A. and U.S.O.C.; all sports federations, and professional athletic organizations.
The Iowa Central Community College Department of Athletics will not condone or tolerate the use of Anabolic Steroids by the student-athlete.

All of the following have been linked to steroid use:

1. Aggressiveness leading to violence
2. Mood swings
3. Psychiatric disorders, psychotic episodes
4. Acne
5. Balding
6. Hypertension
7. High blood cholesterol
8. Cardiac arrhythmias
9. Diminished libido
10. Atrophy of the testicles
11. Impotence
12. Stunted growth
13. Kidney disease
14. Liver damage
15. Enlarged prostate
16. Prostatitis
17. Breast enlargement (males)

(In Females)
1. Menstrual problems
2. Breast atrophy
3. Excessive hair growth
4. Enlarged clitoris
5. Deepening of voice
Iowa Central Community College
Intercollegiate Athlete
Acknowledgement and Consent to Alcohol and Drug Testing and Release of Information

(If the intercollege athlete is less than 18 years of age, his or her parent or guardian must also read and sign this document).

I acknowledge that while as a member of an athletic team at Iowa Central Community College, I may be subject to random and or reasonable suspicion alcohol and drug testing by the use of a urine or saliva sample and that the test will be conducted by and under the supervision of qualified individuals. I hereby consent to undergo random and or reasonable suspicion alcohol and drug testing by the use of a urine or saliva sample for the presence of drugs or other substances.

I understand that all specimens will be analyzed by a laboratory accredited by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). All specimens will be identified only by a code number and strict chain of custody procedures will be followed to ensure the integrity of the collection process.

I understand that if I am on any prescription or over-the-counter medication I must have that information on file with the team physician at Iowa Central Community College as some medications may impact drug test results. I understand that I have the responsibility to provide this information to the team physician at Iowa Central Community College and that such information will be required to be considered by the Intercollegiate Athletic Director at Iowa Central Community College only if I have provided the required information to the Iowa Central Community College team physician before an alcohol and drug test occurs.

By signing this document, I also authorize that the results of the alcohol and drug test(s) be released by the testing laboratory to the Intercollegiate Athletic Director of Iowa Central Community College and/or his or her designee and that the Intercollegiate Athletic Director may disclose the alcohol and drug test(s) results to Iowa Central Community College coaches of athletic team(s) of which I am a member.

By signing this document, I further authorize the alcohol and drug test results to be released under the Family Educational Rights and Privacy Act.

I state that this consent is voluntarily given. I understand that I may revoke this consent at any time by written revocation to the Intercollegiate Athletic Director of Iowa Central Community College. I understand that information released prior to any written revocation by me will not be considered a breach of this consent.

I understand that if I refuse to undergo alcohol and drug testing at any time requested by Iowa Central Community College or refuse to sign or revoke this acknowledgement and consent and release of information I will be ineligible to participate in intercollegiate athletics at Iowa Central Community College and that my refusal may lead to termination of my scholarship as applicable.

I acknowledge that my signature below signifies that I have read and understand the above and agree as stated above.

I, the undersigned, understand that by typing my name in the provided box an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Student Athlete signature: ______________________________________ Date: __________

Parent/Guardian signature (if Student Athlete is under 18 years of age):

________________________________________ Date: __________
Iowa Central Community College
Participant in Intercollegiate Athletics
Consent to Release Alcohol and Drug Testing Information to Parents/Guardians.

I, the undersigned, have given written consent to undergo alcohol and drug testing for the presence of alcohol and drugs or other substances in accordance with the Iowa Central Community College Athletics Department drug testing procedure.

By signing this form, I authorize the results of the alcohol and drug testing to be released to my Parents/Guardians by the Iowa Central Community College Intercollegiate Athletic Director or other designated administrator.

I understand that this consent is voluntary. I may revoke this consent at any time by submitting written revocation of this consent to the Intercollegiate Athletic Director. If this consent is revoked, I understand that information released prior to the revocation would not be considered a breach.

I understand that my signature below signifies that I have read and understand the above and agree as stated above.

I, the undersigned, understand that by typing my name in the provided box an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Signature of Student Athlete: _______________________________ Date: ____________
Iowa Central Community College
Concussion Statement

Please read the following language carefully: (if you are under 18 years of age, your parent or guardian must also read and sign acknowledging having fully read and understand this Concussion Statement.

As an intercollegiate athlete at Iowa Central Community College:

- I acknowledge that I have read and understand the rules and protocols of Iowa Central Community College's Sports Medicine Policy on Management of Mild Traumatic Brain Injury/Concussion;
- I agree to comply with the rules and protocols of Iowa Central Community College's Sports Medicine Policy on Management of Mild Traumatic Brain Injury/Concussion if suspected or diagnosed with a concussion;
- I agree to answer all questions honestly if a concussion evaluation is warranted;
- I agree to accept the responsibility to report to the Iowa Central Community College's Head Athletic Training and or to the team physician all injuries and illnesses, including signs and symptoms of concussions while participating in intercollegiate athletics at Iowa Central Community College;
- I agree to adhere to Iowa Central Community College coaches', assistant coaches', athletic trainers', and team physician's health and safety instructions, including the rules of the sport or sports in which I am participating while participating in contests, practices, training sessions and related travel to effectively reduce the risks of injury; and
- I acknowledge that I have fully read and understand the attached Concussion Fact Sheet and understand the importance of honestly disclosing any symptoms to my athletic trainer.

I understand that my signature below signifies that I have read and understand the above and the attached Concussion fact sheets and agree as stated above.

I, the undersigned, understand that by typing my name in the provided box an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Student’s Signature: ________________________________ Date: __________
Sport(s): ____________________________________________
Print Name: __________________________________________

If under 18 years of age,
Parent/Guardian Signature: ____________________________ Date: __________
CONCUSSION
A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?
A concussion is a brain injury that:
- Is caused by a blow to the head or body.
- From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- Can happen even if you do not lose consciousness.

HOW CAN I PREVENT A CONCUSSION?
Basic steps you can take to protect yourself from concussion:
- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbow, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?
You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
Concussion symptoms include:
- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or grumpy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?
Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion.
Sports have injury timeouts and player substitutions so that you can get checked out.
Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.
Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play.
A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.
Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.
WHEN IN DOUBT, GET CHECKED OUT.
For more information and resources, visit www.nCIA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.

I acknowledge that I have fully read and understand the Concussion Fact sheet. I fully understand the importance of honestly disclosing any symptoms to my athletic trainer.

Signed: ___________________________                    Date: ___________________________
CONCUSSION 101

HOW TO REMAIN SAFE ON THE FIELD

- Make sure all helmets and safety equipment are sport specific, properly fitted and refurbished according to industry standards.
- Follow sports safety rules and use proper techniques.
- Practice good sportsmanship.

YOU HAVE A CONCUSSION – NOW WHAT?

- **Report symptoms:** Tell a coach, parent or athletic trainer if you suspect an athlete has a concussion.
- **Get checked out:** Only a health care professional experienced with concussion management can tell if a concussion has occurred and when it is OK to return to play.
- **Get plenty of rest:** Immediately after the concussion is sustained, rest is recommended. This includes keeping a regular sleep routine and avoiding activities that require a lot of concentration.
- **Give time to recover:** It's important to allot time to heal. Another concussion sustained while the brain is healing can result in long-term problems or even death in rare cases.
- **Take it slow at first:** After the physician or athletic trainer gives the OK to return to activity, an athlete shouldn't jump in at all once. The athletic trainer will work with the athlete to develop a safe plan for progressively returning to play.
- **Address concerns:** If there are concerns, don't hesitate to bring them up with a health care provider (athletic trainer, physician, etc.).

- **A concussion is defined as a** “trauma-induced alteration in mental status that may or may not involve loss of consciousness.”
- **This can be caused by a** bump, blow or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth.
- **Concussion signs and symptoms can appear immediately or not be noticed until days or even weeks after the injury.**

SOURCES: NATA, Sanford Orthopedic Sports Medicine, Center for Disease Control and Prevention, Heads Up Concussion, Fifth Annual Youth Sports Safety Summit

Illustration by: Thinkstock/bakhtiar_rein
Infographic courtesy of the National Athletic Trainers' Association
Iowa Central Community College
Participant in Intercollegiate Athletics
Authorization to Obtain and Release Medical Information

I, the undersigned, hereby:

- authorize Iowa Central Community College to release or obtain personal medical records to a hospital, athletic team physician, Iowa Community College nurse, physicians, athletic trainer, and or other provider of medical services in order to maintain my/son/daughter’s well-being. In accordance with FERPA and HIPAA, this information is to be released or obtained on the condition that Iowa Community College will not permit any other party access to the information without my express written consent or express written consent by other legally responsible party;

- authorize the Iowa Central Community College athletic team physician, Iowa Community College nurse, other physicians, hospitals, and or any other provider of medical services to release medical information acquired in the course of my examination or treatment to the Iowa Central Community College Head Athletic Trainer for the purpose of advising medical status, care of, and eligibility for returning to intercollegiate athletic activity(ies);

- acknowledge and authorize that any protected health information released to or obtained by the Iowa Central Community College Head Athletic Trainer can be disclosed to the Iowa Central Community College Intercollegiate Athletic Director, the Iowa Central Community College coaching staff, the athletic team physician, the Iowa Community College nurse, and or any other provider of medical services for treatment purposes, and

- acknowledge that Iowa Central Community College is not authorized to release any of my medical information to the media, sport information personnel and/or any other non-covered entity in accordance with FERPA and HIPAA guidelines unless a signed authorization is obtained first for me or from my parent or guardian.

The undersigned understand that an electronic signature (an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record) is equal to a legal signature.

Student Athlete Printed Name: ________________________________

Student Athlete Signature: ____________________________ Date: ________________

Parent/Guardian Signature (if under 18): ____________________________

Date: ________________
I, the undersigned, give authorization to the Head Athletic Trainer and or team physician at Iowa Central Community College to release complete copies of my medical records including physicals, injury records, treatment and rehabilitation records, prognosis, and diagnosis of any and all injury and ailments, past and present, to any four year University or College medical staff where I am interested attending and whom I designate in writing by name and mailing address or email address to the Head Athletic Trainer and or team physician at Iowa Central Community College.

Student Athlete signature: _____________________________________________ Date: __________
Written Warning
To: Participant in Intercollegiate Football at Iowa Central Community College

WARNING:

Do Not use a helmet to butt, ram, or spear an opposing player.

This is a violation of football rules and such use can result in severe head or neck injury, paralysis, or death to you and possible injury to your opponent.

The above warning is issued to you as a student athlete in the intercollegiate football program at Iowa Central Community College and to inform you of the possible dangers and catastrophic injuries that may occur while playing football.

By signing this Written Warning statement, you agree that you will not use a helmet to butt, ram, spear and opposing player and that you understand the possible dangers and catastrophic injuries that may occur while playing football and if you fail to comply with this warning.

Signature of Student Athlete: _____________________________________________
Date: ___________________________.
INTERTOLLEGATE ATHLETICS
PHYSICAL EXAMINATION

Iowa Central Community College
ATHLETIC TRAINING

<table>
<thead>
<tr>
<th>Student Athlete</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Sport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Height _____________________ Weight _______________
Blood Pressure _______________ Pulse _________________

PERSONAL EXPERIENCE
Has the student-athlete ever experienced:

a) Prior exertional chest pain __________________________ Yes  No
b) Prior exertional syncope/ near syncope __________________________ Yes  No
c) Excessive, unexplained shortness of breath __________________________ Yes  No
d) Excessive, unexplained fatigue with exercise __________________________ Yes  No
e) Heart rate over 120 beats/minute (Heart racing?) __________________________ Yes  No
f) Resting BP> 140/90 mmHg (Been told BP is High) __________________________ Yes  No
g) Nausea, abdominal discomfort, dizziness, general fatigue __________________________ Yes  No
h) Had any concussions __________________________ Yes  No
i) Do you wear glasses or contacts Glassses Contacts None

List any Current Medicines: _________________________________________________
Allergies: _______________________________________________________________
Comments:______________________________________________________________________________
_______________________________________________________
______________________________________________________________________________________

HISTORY
Is there a personal or family history of:

a) Heart murmur or __________________________ Yes  No
b) High blood pressure __________________________ Yes  No
c) Family history of premature death or complications from cardiovascular disease in a relative younger than the age of 50 __________________________ Yes  No
d) Family history of hypertrophic cardiomyopathy or dilated myopathy, long QT syndrome, or Marfan’s Disease __________________________ Yes  No

MUSCULOSKELETAL NORMAL ABNORMAL FINDINGS INITIALS
Neck
Back
Shoulder/Arm
Elbow/Forearm
Wrist/Hand
Hip/Thigh
Knee
Leg/Ankle
Foot
Signed __________________________ Health Care Provider Date ___________
### Cardiac Screen

**Student Athlete** | **Social Security Number** | **Date of Birth** | **Sport**
--- | --- | --- | ---

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Physical Exam**

<table>
<thead>
<tr>
<th>a) Absence or discrepancy between femoral and brachial pulse</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Precordial auscultation (supine and standing)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>c) Brachial blood pressure, sitting (see Physical Exam Sheet)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>d) Arm span greater than standing height</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>e) Severe kyphoscoliosis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>f) Concave chest deformity (pigeon chest)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>g) “Thumb and/or wrist” sign</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>h) High arched palate/hyperextensible joints/pes planus</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>i) Inguinal hernias</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>j) Nearsightedness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>k) Murmurs of aortic or mitral regurgitation and non-ejection click</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Comments:** _______________________________________________________________________

### Medical

<table>
<thead>
<tr>
<th>Appearance</th>
<th>E/E/N/T</th>
<th>Lymph Nodes</th>
<th>Heart</th>
<th>Pulses</th>
<th>Lungs</th>
<th>Abdomen</th>
<th>Genitalia (Males Only)</th>
<th>Skin</th>
</tr>
</thead>
</table>

**Clearance Is:**

1. **Without Restriction**
2. **Pending**
3. **Deferred**

**Comments:** __________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Signed: ___________________________ Health Care Provider   Date __________________________
Attention: ATHLETIC TRAINING

Address: One Triton Circle

City: Fort Dodge  State: IA  Zip: 50501

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: ___________________________  Sport: ___________________________

Social Security No or Passport No: ___________________________  Date of Birth: ____________

College Address: ___________________________  College Phone: (     )

Home Address: ___________________________  Home Phone: (     )

City: ___________________________  State: ________  Zip: ______

FATHER/GUARDIAN INFORMATION

Father's Name: ___________________________  Mother's Name: ___________________________

Social Security No.: ___________________________  Social Security No.: ___________________________

Date of Birth: ___________________________  Date of Birth: ___________________________

Address: ___________________________  Address: ___________________________

Employer: ___________________________  Employer: ___________________________

Address: ___________________________  Address: ___________________________

Telephone: (     )  Telephone: (     )

Medical Insurance Company or Plan: ___________________________

Address: ___________________________

Policy Number: ___________________________

Telephone: (     )  Telephone: (     )

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

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

Is a second opinion required before surgery?  □ Yes  □ No  Is a second opinion required before surgery?  □ Yes  □ No
AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency for purposes of obtaining information necessary to process a claim for 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 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 the 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 us 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 the 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 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 to us pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

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

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

Signature of Claimant (if claimant is 18 or older) ___________________________ Date ___________________________.

Signature of Authorized Representative of Next of Kin ___________________________ Date ___________________________.

Relationship of Authorized Representative or Next of Kin to Claimant ___________________________