GateWay Geckos Preparticipation Physical Evaluation

HISTORY FORM

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

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ______ Age ______ Grade ______ School ______________ Sport(s) ______________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

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Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines:__________________ ☐ Pollens ☐ Food:__________________ ☐ Stinging Insects:_______________

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery? Explain procedure & List Dates		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ______________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down- syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________________ Signature of parent/guardian ______________________ Date ______________

PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

EKG (Current **EKG REQUIRED**) Attach EKG Result Sheet & Clearance						
EKG Date	**MM**	**DD**	**YY**		**NORMAL**	**ABNORMAL FINDINGS**

Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height	Weight	☐ Male ☐ Female
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

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☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the athlete/ parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician ______________________________, MD, DO, PA-C, NP

Assumption of Risk and Release of Liability

I ________________________, freely choose to participate in the athletic program (henceforth referred to as the "Program") at GateWay Community College. In consideration of my participation in this program, I agree as follows:

RISKS INVOLVED IN PROGRAM: Participation in all sports requires an acceptance of risk of injury, such as pre-season physical examinations, proper facilities maintenance, and instruction of correct sports technique, we attempt to provide a safe, competitive environment for all student athletes. In addition we have team physicians, (general practitioner and orthopedic specialist) and certified athletic trainers to assist you with injury prevention and treatment.

In spite of these efforts, injuries do occur. Athletic competition, by its very nature results in numerous uncontrollable situation where injuries cannot be avoided. As an athletic participant, there is always the possibility that you may sustain an injury. The injury may range from a minor one to one of great severity and which could result in deformity, paralysis, or even death.

HEALTH AND SAFETY: I have been advised to consult with a medical doctor with regard to my personal medical needs. I state that there are no health-related reasons or problems that preclude or restrict my participation in this Program. I have obtained the required immunizations, if any.

I recognize that GateWay Community College is not obligated to attend to any of my medical or medication needs, and I assume all risk and responsibility therefore. In case of a medical emergency occurring during my participation in this Program, I authorize in advance the representative of GateWay Community College to secure whatever treatment is necessary, including the administration of an anesthetic and surgery. GateWay Community College may (but is not obligated to) take any actions it considers to be warranted under the circumstances regarding my health and safety. Such actions do not create a special relationship between the Maricopa County Community College District (MCCCD) and me. I release the MCCCD, its officers, officials, employees, volunteers, students, agents and assigns from all liability for any bodily injury or damage I sustain as a result of any medical care that I receive resulting from my participation in Program, as well as any medical treatment decision or recommendation made by an employee or agent of the MCCCD. I agree to pay all expenses relating thereto and release GateWay Community College from any liability for any actions. I have been advised that I am covered under a secondary athletic accident injury insurance policy for injuries sustained while participating in athletics at GateWay Community College. I understand that any outstanding debts incurred as a result of medical treatment for that injury is my sole responsibility.

ASSUMPTION OF RISK AND RELEASE OF LIABILITY: Knowing the risks described above, and in voluntary consideration of being permitted to participate in the Program, I agree to release, indemnify, and defend GateWay Community College and their officials, officers, employees, agents, volunteers, sponsors, and students from and against any claim which I, the participant, my parents or legal guardian or any other person may have for any loses, damages or injuries arising out of or in connection with my participation in this Program.

SIGNATURE: I indicate that by my signature below that I have read the terms and conditions of participation and agree to abide by them. I have carefully read this Release Form and acknowledge that I understand it. No representation, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. This Release Form shall be governed by the laws of the State of Arizona which shall be the forum for any lawsuits filed under or incident to this Release Form of to the Program. If any portion of this Release Form is held invalid, the rest of the document shall continue in full force and effect.

______________________________________ ______________________

Signature of Student (and Parent/Guardian if under 18) Date

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Print or Type Full Name

This form authorizes the Maricopa Community Colleges and its colleges to release certain personal information about you for educational purposes, including information that may be subject to the Family Education Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please read it carefully.

“Personal information” means specific information about you, including education records and personal health information, that the Maricopa Community Colleges or its college(s) disclose: as a condition to permitting you to participate in college intercollegiate athletics; to benefit you in pursing athletics beyond the Maricopa Community Colleges; to address your health as you play college intercollegiate athletics; or to highlight the colleges’ intercollegiate athletics programs or your participation in them. It includes, as is appropriate to the specific use, your name, address, telephone number, date and place of birth, medical or health conditions, major field of study, participation in officially recognized activities and intercollegiate athletics, weight and height, dates of college attendance, degrees and awards, grade point average, email address, intercollegiate athletics in which you have participated and positions played, the name of your high school(s), the name of any other postsecondary institution you have attended, and your home town. The term also includes any photo, portrait, video clip, or other image of you created by any person for or on behalf the Maricopa Community Colleges, its colleges or any other educational institutions that you have attended.

By signing this form, I certify that:

1. I have read and understand the definition of “personal information” specified in this form.

2. I authorize the release of personal information for the purposes specified in this form except that listed here:____

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3. I authorize FULL DISCLOSURE of personal information concerning any athletic injury I may sustain while participating in intercollegiate athletics at a college.

4. I understand that some or all of the following persons may be told about my health conditions: coaches, media, parents, athletic directors, team physicians, doctors’ staff, referral sources, and the Maricopa Community Colleges insurance brokers or companies.

5. I authorize the use and disclosure of personal information for the following purposes:
   - In promotional literature or video presentations about college athletic programs or about the Maricopa Community Colleges in general;
   - In any Internet website maintained by or for the benefit of the Maricopa Community Colleges and its colleges;
   - To disseminate to the National Junior College Athletic Association concerning my participation in inter-collegiate athletics;
   - To include in any program or publication about an athletic event sponsored by the Maricopa Community Colleges or its colleges or by any other organization and in which the Maricopa Community Colleges or its colleges is participating;
   - To disseminate to other postsecondary institutions in connection with their recruitment activities;
   - To release to any newspaper, broadcasting entity, or any other media outlet;
   - To disseminate to any high school or other educational institution that I have attended.

I understand that I have the right not to consent to the release of my education records and to receive a copy of them on request. This consent shall remain in effect until revoked by me, in writing, and delivered to the Maricopa Community Colleges. Any revocation will not affect disclosures that the Maricopa Community Colleges made before receiving my revocation.

____________________________________	____________________________________
Signature of Student and Parent/Guardian if Student is under 18	Print Name of Student
	____________________________________
Date: ________________________________	Print Name of Parent/Guardian if applicable

Athletic Accident Insurance

As an athlete at GateWay Community College you are provided with a **secondary accident insurance policy**. This insurance policy is **NOT** a health insurance policy and may not be used in cases of illness. **This is an accident insurance policy that provides supplemental (secondary) coverage for all injuries sustained while participating in intercollegiate athletics.**

This means that your personal insurance (primary insurance) carrier **WILL BE** utilized and they will pay their normal benefits before the school's supplemental accident insurance will pay any benefits. For example: if you belong to an HMO or PPO (CIGNA, Intergroup, Aetna, BC/BS, etc.), you **must** follow their procedure for filing a medical claim. After your private insurance has paid its portion of the benefits, then the secondary accident insurance will apply to the remaining portion of the medical bill. As with all insurance carriers, the supplemental accident insurance has its restrictions and exclusions. Therefore, all claims **must** be filed as soon as possible with the athletic trainer to prevent claim denial due to time restrictions. In addition, the supplemental accident insurance is **not required** to pay all remaining balances after the primary insurance carrier has been utilized. If this is the case, the remaining balance after both the primary and supplemental insurance have been utilized, **is the responsibility of the student athlete.**

The athletic trainer will assist you with filing a claim with the supplemental accident insurance carrier. It is important to note that all medical bills are the **responsibility of the student athlete. It is also the responsibility of the student athlete that all medical claims are properly filed with their own personal (primary) insurance carrier, and with the school provided supplemental accident insurance carrier.** If a medical claim is not filed properly or the primary insurance carrier's guidelines are not followed the student athlete will be responsible for any and all medical bills. At times the supplemental accident insurance policy will require additional information from the student athlete. Again this is the sole responsibility of the student athlete to follow through with all additional requests from both the primary and supplemental insurance companies. Failure to follow through with these requests can lead to failure and delay of any payment for medical treatments and the possibility of the student athlete going into collections.

My signature verifies that I understand the accident insurance policy provided by GateWay Community College is a supplemental insurance policy. I also understand that if I do not follow the claim filing procedures set forth by my primary insurance carrier and the school provided supplemental insurance carrier, **I will be responsible for all medical bills.**

Printed name: ____ Sport: ________________________

Signature: ____ Date: ________________________

Signature of Parent/Guardian if Student athlete is under 18:

____ Date: ________________________

___ I am NOT covered under a group insurance and/or have no insurance coverage. I understand that I am responsible for any medical bills not covered by the secondary (supplemental) accident only insurance.

___ I am covered under the following plan:
Name of Group Insurance Company: ____
Group #___________________ Policy #________________________________ Type ___HMO ___PPO ___Other:
Billing Address____
____
Phone Number ____
Primary Policy Holder ___________________________ DOB _____________ Relationship________
Address____ State_______ Zip____________

You must attach a copy of your insurance card (front and back) in order for this form to be complete.

In case of Emergency, please notify ______________________________ Relationship_______________

Home Phone ________________ Business Phone ________________ Cell Phone ___________________

Address____ State_______ Zip__________
Athletes Medications / Allergies ____