



PREPARTICIPATION PHYSICAL EXAMINATION FOR ATHLETICS

Last name _____	First name _____	Sex _____	Age _____	Today's date _____
Social Security No. _____		Date of Birth _____		Sports _____
Local address _____		City _____	ZIP _____	Phone No. _____
Parent's address _____		City _____	ZIP _____	Phone No. _____

All questions must be answered. Failure to disclose pertinent information regarding your medical history may invalidate your insurance coverage and may cause you to forfeit your eligibility to participate in intercollegiate athletics. Any health problems past or present must be discussed with the examining physician. Any "yes" questions must be explained below by indicating the number and a brief explanation.

	Yes	No		Yes	No
1 Have you had a medical illness or injury since you last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	9 Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>			
3 Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	10 Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or your position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your athletic performance?	<input type="checkbox"/>	<input type="checkbox"/>			
4 Do you have any allergies (for example to pollen, medicine, foods, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	11 Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
5 Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12 Have you ever had a sprain, strain, or swelling after an injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, then check the appropriate box and explain below		
Have you ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip		
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh		
Has any family member or relative died of heart problems or of sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/calf		
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm <input type="checkbox"/> Foot		
6 Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	13 Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
7 Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	14 Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	15 Have you had a tetanus shot?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Please list the date of your most recent booster (shot):		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>			
8 Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	16 FEMALES ONLY		

Explain "yes" answers here: _____

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

Signature of student-athlete _____ Signature of parent/guardian (if under 18) _____ Date _____



Preparticipation Physical Examination for Athletics

Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ % Body Fat: _____ Pulse: _____ BP: _____ / _____ (_____ / _____)

Vision: R20 / _____ L20 / _____ Corrected: Y / N Pupils: Equal / Unequal

	Normal	Abnormal Findings	Initials
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitals (males)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not Cleared for: _____ Reason: _____

Recommendation: _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____, MD - DO - NP - PA



COLLEGE
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VOLUNTARY ACTIVITIES PARTICIPATION FORM
ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

I, the undersigned, wish to participate in the College of the Redwoods sponsored activities of intercollegiate athletics/sports.

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses, which may result from participating in these activities, include, but are not limited to, the following:

- | | |
|------------------------------|--------------------------|
| 1. Sprains/strains | 5. Paralysis |
| 2. Fractured bones | 6. Loss of eyesight |
| 3. Unconsciousness | 7. Communicable diseases |
| 4. Head and/or back injuries | 8. Death |

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the College of the Redwoods for course credit or for completion of graduation requirements.

I understand and acknowledge that in order to participate in these activities, I agree to assume liability and responsibility for any and all potential risks, which may be associated with participation in such activities.

I understand, acknowledge, and agree that the College of the Redwoods, its employees, officers, agents, or volunteers shall not be liable for any injury/illness suffered by my son/daughter which is incident to and/or associated with preparing for and/or participating in this activity.

I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES PARTICIPATION FORM and that I understand and agree to its terms.

I HAVE READ, UNDERSTOOD AND VOLUNTARILY SIGNED THIS RELEASE

Student-Athlete (If 18 years of age or older)

Date

Printed Name

Parent/Legal Guardian (If under 18 years of age)

Date

Printed Name

A signed VOLUNTARY ACTIVITIES PARTICIPATION FORM must be on file with the College of the Redwoods Athletic Trainer before a student will be allowed to participate in intercollegiate athletics/sports.



COLLEGE
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VOLUNTARY ACTIVITY WAIVER RELEASE AND INDEMNITY AGREEMENT

For and in consideration of permitting the undersigned to participate in intercollegiate athletics, the undersigned hereby voluntarily releases, discharges, waives and relinquishes any and all actions or causes of action for personal injury, property damage or wrongful death occurring to him/herself arising as a result of engaging or receiving instructions in said activity or any activities incidental thereto wherever or however the same may occur and continue, and the undersigned does for him/herself, his/her heirs, executors, administrators and assigns hereby release, waive, discharge and relinquish any action or causes of action, aforesaid, which may hereafter arise for him/herself and for his/her estate, and agrees that under no circumstances will he/she or his/her heirs, executors, administrators and assigns prosecute, present any claim for personal injury, property damage or wrongful death against College of the Redwoods or any of its officers, agents, volunteers or employees for any of said causes of action, whether the same shall arise by the negligence of any of said persons, or otherwise.

IT IS THE INTENTION OF THE UNDERSIGNED BY THIS INSTRUMENT, TO EXEMPT AND RELIEVE THE COLLEGE OF THE REDWOODS FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE.

The undersigned, for him/herself, his/her heirs, executors, administrators or assigns, agrees that in the event any claim for personal injury, property damage or wrongful death shall be prosecuted against the College of the Redwoods he/she shall indemnify and save harmless the same the College of the Redwoods from any and claims or causes of action by whomever or wherever made or presented for personal injuries, property damage or wrongful death.

The undersigned acknowledges that he/she has read the foregoing Waiver of Liability Notice and the foregoing three (3) paragraphs, has been fully and completely advised of the potential dangers incidental to engaging in the activity of intercollegiate athletics, and is fully aware of the legal consequences of signing the within instrument.

AUTHORIZATION TO CONSENT TO TREATMENT

We, the undersigned, do hereby consent and authorize any duly authorized doctor, emergency medical technician, hospital or other medical facility to treat or attempt to treat the participant for any injuries received by the said participant while he or she participates in any activity of the College of the Redwoods, or while traveling to or from or competing in any College of the Redwoods activity. We further authorize any licensed physician to perform any procedure, which he or she deems advisable in attempting to treat or relieve any injuries or any related unhealthy conditions in said participant that may be encountered during any necessary procedure or operation. We further consent to the administration of any anesthesia as deemed advisable by any licensed physician and do hereby further authorize any x-ray examination, medical or surgical diagnosis or treatment, and hospital care to be rendered to the participant in our absence under the general or special supervision and on the advice of a licensed physician, surgeon, anesthesiologist, dentist or other qualified personnel acting under their supervision.

We, the undersigned, realize and appreciate that there is a possibility of complication and unforeseen consequence in any medical treatment, and we assume any such risk on behalf of ourselves and the participant as stated herein. We acknowledge that there has been no warranty made as to the results of any such treatment or diagnostic procedure.

Each of the undersigned expressly acknowledge and agree that they have read and understood the terms of this form, including the VOLUNTARY ACTIVITY WAIVER RELEASE AND INDEMNITY AGREEMENT coupled with the AUTHORIZATION TO CONSENT TO TREATMENT and further state that no oral representation, statements or inducements apart from the foregoing written provisions have been made.

WE HAVE READ, UNDERSTOOD AND VOLUNTARILY SIGNED THIS RELEASE

Student-Athlete (If 18 years of age or older)

Date

Printed Name

Parent/Legal Guardian (If under 18 years of age)

Date

Printed Name



Emergency Contact Information

Athlete's Name: _____ Sport: _____

Social Security Number : _____ DOB: _____

Mobile Phone: _____ 2nd Phone: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact #1

Name: _____ Relationship: _____

Mobile Phone: _____ 2nd Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact #2

Name: _____ Relationship: _____

Mobile Phone: _____ 2nd Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact #3

Name: _____ Relationship: _____

Mobile Phone: _____ 2nd Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical Insurance Information

College of the Redwoods offers accident insurance, which is a secondary policy, with limited coverage. If you have other insurance coverage, that policy will need to cover your expenses first before College of the Redwoods' policy will cover anything. If you do not have insurance coverage, then College of the Redwoods' policy will become the primary policy.

Insurance information is one of the first things a doctor's office or hospital will ask for. Without that information proper medical attention could be delayed. It is for this reason that it is important for the Athletic Trainer to have your insurance information. It is also important to note that some insurance carriers are not valid or are not accepted in Humboldt County, and in some instances your insurance carrier will require you to return home for treatment. Please check with your insurance provider for further details.

Are you currently covered by any health or medical insurance? ☐ Yes ☐ No

If yes, then fill out this form and include a copy of the front and back of your insurance card.

Insurance Company Name:

Type of Insurance Policy:

☐ PPO ☐ HMO ☐ Not sure

Policy Number:

Group Number:

Member ID Number:

Insurance Company Address:

Insurance Company Phone Number:

Name of Policy Holder:

Relationship to you:

Policy Holder's Social Security #:

DOB:

Is Policy through an Employer?

☐ Yes ☐ No

If Yes: Employer Name:

Address:
