



# **ARIZONA WESTERN COLLEGE** **SPORTS MEDICINE GUIDELINES**

## **I. Pre-Participation Policy**

The Arizona Western College Department of Athletics will provide medical care for any injury or illness suffered by a student-athlete, who is on a particular sport's participation roster, provided that such injury or illness was a direct result of participation in sanctioned athletic department-related activities held on-campus or off-campus.

All prospective and continuing student-athletes at Arizona Western College will complete a pre-participation evaluation by a licensed physician. The physician will assume the responsibility for determining the medical status of the student athlete. If at any time a student athlete is referred to a physician, clearance to return to play is to be provided by the physician. If a student-athlete is injured but does not require a referral to a physician, return to play is to be determined by the head athletic trainer on staff.

## **II. Pre-Participation Procedure**

It is mandatory for all prospective and returning student-athletes at Arizona Western College to complete a pre-participation packet PRIOR to being allowed to participate in any athletic-related activity. This pre-participation packet will include: medical history, insurance information/waiver, medical information release form, and a physical examination to be conducted by a physician. This packet will be mailed to the student-athlete by the head coach, or may be picked up in the athletic department office. **AGAIN, THIS COMPLETED PACKET MUST BE RETURNED PRIOR TO PARTICIPATING IN ANY ATHLETIC-RELATED ACTIVITY.**

### **A. Medical History**

Instructions will be provided for proper completion of the forms. Please read and answer all questions carefully, submitting any requested dates or medical clearances as requested.

### **B. Insurance Information/ Waiver**

All student-athletes must complete a current insurance information form, and provide a copy of the insurance card. Each student-athlete is responsible for updating his or her personal insurance information, should it change over the course of the year. Failure to do so may result in the student-athlete incurring all medical expenses. Arizona Western College serves as the **SECONDARY PROVIDER** to any existing coverage for in-season athletic accidental injuries. Any stated pre-existing injuries are to be covered by the athlete's primary insurance.

***Important:*** Any explanation of benefits (EOB) from the primary insurance must be submitted to Health Special Risk (HSR). **The student-athlete is responsible for contacting the medical providers and insurance companies when bills have been received and/or requested documents have been attained.**

### **C. Medical Information Release Form**

All medical information will be kept confidential, only being disclosed to those individuals/groups providing care for the student-athlete. Any other individual/groups requesting medical information must first have a written and signed release from the student-athlete.

### **D. Physical Examination**

All new and returning student-athletes must have an athletic physical examination PRIOR to participation in any athletic practices or competitions. Student-athletes are encouraged to have their physicals completed by their family physician. The physician administering the exam is responsible for clearing the student-athlete to participate. No athlete will be allowed to participate in any athletic-related activity without being cleared by a licensed physician.

# AWC Sports Medicine Pre-Participation Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sport: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Class: Fresh / Soph SSN#: \_\_\_\_\_ Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Emergency Contact Information**

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_

## Insurance Information

Do you have your own health insurance or are you covered under your parents?

- If, YES, Please Fill Out Form Below
- If, NO, Please Read and Sign AFFIDAVIT Below

I. Student/Athlete's Name: \_\_\_\_\_  
 Student/Athlete's Employer: \_\_\_\_\_  
 Insurance Co: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
 Insurance Policy Number: \_\_\_\_\_

II. Mother's Employer: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 Insurance Co: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
 Insurance Policy Number: \_\_\_\_\_  
 Is the student covered under this policy? YES \_\_\_\_\_ NO \_\_\_\_\_

III. Father's Employer: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 Insurance Co: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
 Insurance Policy Number: \_\_\_\_\_  
 Is the student covered under this policy? YES \_\_\_\_\_ NO \_\_\_\_\_

The above information is correct to the best of my knowledge and I am responsible for providing updated insurance information should it change. I know this is the primary health insurance policy used if injured during an in-season sanctioned athletic event.

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### AFFIDAVIT

I, the undersigned, have read Arizona Western College's Policies and Procedures and understand the payment procedures for the HSR plan. At this time **I have no other insurance coverage.** I understand that I am responsible for reimbursing HSR on any paid claim should it be found later that I do have insurance coverage. I also understand that I am responsible for providing updated information should I gain insurance coverage throughout the year.

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical Information Release

I, \_\_\_\_\_, hereby allow Arizona Western College to disclose any medical information to:

- Parents (if 18 years of age or older)
- Media
- Other colleges and/or Universities
- None

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach copy of insurance card here



# AWC Sports Medicine Physical Examination Form

## Athlete Information:

Name: \_\_\_\_\_ Sport: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Class: Fresh / Soph SSN#: \_\_\_\_\_ Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

## Emergency Contact Information:

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address (if different from above): \_\_\_\_\_

(To be filled out by a physician)

## Physical Examination:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_ Respiration: \_\_\_\_\_  
 Vision: R \_\_\_\_\_ L \_\_\_\_\_ Contacts Y/N \_\_\_\_\_ Hearing: R \_\_\_\_\_ L \_\_\_\_\_  
 Immunizations: DIP/TE \_\_\_\_\_ (date) MMR \_\_\_\_\_ (date)

### General

- \_\_\_\_\_ Head/Scalp
- \_\_\_\_\_ Eyes/Pupils
- \_\_\_\_\_ Nose/Sinus
- \_\_\_\_\_ Throat/Pharynx
- \_\_\_\_\_ Thyroid
- \_\_\_\_\_ Lymph Nodes
- \_\_\_\_\_ Heart Conditions
- \_\_\_\_\_ Chest/Lungs
- \_\_\_\_\_ Spleen
- \_\_\_\_\_ Liver
- \_\_\_\_\_ Abdomen
- \_\_\_\_\_ Hernial Rings
- \_\_\_\_\_ Genitalia
- \_\_\_\_\_ Inguinal Nodes
- \_\_\_\_\_ Skin
- \_\_\_\_\_ Nailbeds – Fingers / Toes

### Orthopaedic

- \_\_\_\_\_ Neck
- \_\_\_\_\_ Jaw
- \_\_\_\_\_ Shoulders
- \_\_\_\_\_ Elbows
- \_\_\_\_\_ Wrists
- \_\_\_\_\_ Fingers
- \_\_\_\_\_ Spine
- \_\_\_\_\_ Ribs/Sternum
- \_\_\_\_\_ Pelvis
- \_\_\_\_\_ Hips
- \_\_\_\_\_ Knees
- \_\_\_\_\_ Ankles
- \_\_\_\_\_ Feet/Toes

## Musculoskeletal:

Upper Extremity: R \_\_\_\_\_ L \_\_\_\_\_  
 Lower Extremity: R \_\_\_\_\_ L \_\_\_\_\_  
 Back: \_\_\_\_\_ Torso: \_\_\_\_\_  
 Gait Pattern: \_\_\_\_\_

## Neurological:

Reflexes: \_\_\_\_\_ Atrophy: \_\_\_\_\_ Paralysis: \_\_\_\_\_

Are other Tests/Exams needed? Yes \_\_\_\_\_ No \_\_\_\_\_ What? \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Athletic Participation Clearance:

- Cleared
  - Cleared after completing evaluation/ Rehabilitation for \_\_\_\_\_
  - Not Cleared for:
    - o Collision
    - o Contact
    - o Non-contact
- Due to: \_\_\_\_\_

Examining Physician: \_\_\_\_\_ MD, DO, NP, PA-C Date of Exam: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(Please attach copy of business card)

# **AWC Sports Medicine Medical History**

## **Athlete History**

**Have you had or ever been treated for, please provide the date and details:**

- |                                  |  |                  |
|----------------------------------|--|------------------|
| Head Injury/Concussion           | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Bell Rung                        | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Neurological Problem/Disorder    | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Dizzy Spells/Fainting            | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Vision Problems/Loss             | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Heat Illness/ Dehydration        | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Muscle Weakness                  | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| High/Low Blood Pressure          | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Anemia                           | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Blood Disorder/                  |  |                  |
| Hemophilia/Sickle Cell Trait     | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Heart Trouble/Chest Pain         | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Kidney/Bladder Problems          | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Ulcers/Stomach Trouble           | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Hepatitis                        | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Tuberculosis                     | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Measles                          | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Epilepsy/Seizures                | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Diabetes                         | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Allergies/Hay Fever              | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Pneumonia/Bronchitis             | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Asthma/Exercise Induced Asthma   | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Menstrual Problems               | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Hernia - Sports/Inguinal         | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Addiction to Drugs/Alcohol       | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Mental Illness/Nervous Breakdown | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Bone/Joint Disorder              | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Joint Dislocation                | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Fracture                         | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |
| Surgery                          | <input type="checkbox"/> NO <input type="checkbox"/> YES | (Details: _____) |

## **Family History:**

**Has anyone in your immediate family experienced, please write who next to answer:**

- |                       |  |       |
|-----------------------|--|-------|
| Heart Attack:         | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT SURE | _____ |
| High Blood Pressure:  | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT SURE | _____ |
| Circulatory Disorder: | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT SURE | _____ |
| Heart Disease:        | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT SURE | _____ |
| Diabetes:             | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT SURE | _____ |
| Asthma:               | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT SURE | _____ |

Are you currently taking any medications? \_\_\_\_\_

Have you ever been Hospitalized?  NO  YES If so, why? \_\_\_\_\_

Are you allergic to **any medications**? \_\_\_\_\_

***I hereby state that, to the best of my knowledge, my answer to the above questions are correct.***

Signature of athlete: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(if athlete is under the age of 18)