

Glendale Community College

ATHLETIC TRAINING FACILITY

Glendale College Vaqueros,

The Glendale Community College Athletic Training Staff is here and ready to begin this new academic and athletic year, with our new Vaquero family. Together, we begin this New Year toward a successful and safe season. To begin this process the following informational forms must be filled out. The only form that is not to be filled out is the Preparation Physical Evaluation form (Pg. 4). **This is to be filled out by a licensed physician ONLY!!!** (Forms filled out by a Chiropractor will not be accepted). It would be much appreciated if all of the forms were completely filled out. This would expedite the process and will be one less responsibility that you would have to worry about. Please note that if you are under the age of 18, a parent or guardian must sign all of the forms.

If you have any questions, please feel free to contact us at (818)240-1000 ext. 5540. The Glendale Community College Athletic Training Facility Staff is excited to begin the new academic year and athletic season. May you have a good and safe year!

Sincerely,

Jose J. Gomez
Athletic Trainer Certified

Claudia J. Alvarez
Athletic Trainer Certified

GLENDALE COMMUNITY COLLEGE

ATHLETIC TRAINING

PERSONAL INFORMATION/CONSENT FORM

Student's Name: _____ Age: _____

Birth Date: _____ Student I.D # _____

Address: _____ Cell Phone # (____) _____

City: _____ State: _____ Zip: _____

Land Line/Home # (____) _____ E-mail Address: _____

Sport(s) _____

Parent/Guardian or Emergency Contact Information

In Case of an emergency who would you like us to contact?

Name _____ Relation _____

Address _____

Emergency Contact Cell Phone Number (____) _____

Emergency Contact Home/Work Phone Number (____) _____

I acknowledge that I am at least eighteen (18) years of age. If I am less than eighteen (18) years of age, a parent or legal guardian will sign with me.

Do you authorize the game physicians, team physicians, family physicians, athletic trainer, coach, school administration, or a medical facility to arrange for treatment and treat your son/daughter?

YES _____ NO _____

GLENDALE COMMUNITY COLLEGE STATEMENT OF ATHLETIC ACCIDENT INSURANCE COVERAGE

The accident insurance policy at Glendale Community College is **Supplemental and limited**. The accident insurance policy **Does Not Guarantee** 100% coverage of any incident and there is also a \$100.00 or a \$50.00 deductible per incident that must be met first, no matter whether the athlete has private insurance or falls under the Glendale Community College insurance policy. The \$100.00 or \$50.00 deductible is the responsibility of the athlete and must be paid first before the college accident insurance policy becomes effective. Our policy is an Accident Insurance Plan. Accident means an unexpected and unintended incident. Injury means sudden bodily trauma caused by an accident and independent of disease or bodily infirmity.

I understand that any cost for medical expense incurred as a result of accidental injury while participating in any scheduled college athletic activity will not be paid under the accident insurance policy carried by Glendale Community College until all payments under any existing policy covering said expenses are exhausted. If no existing insurance is in effect, payment will be made according to the schedule of benefits of the Glendale Community College athletic accident policy. This insurance plan will not cover injuries occurring during normal activities without an accidental cause.

If you participate in Football or Men's and Women's Soccer, there will be a \$100.00 deductible. All other sports will have a \$50.00 deductible.

I understand that the Glendale Community College insurance policy is only a secondary insurance and has certain limitations. I am aware that I am **ULTIMATELY** responsible for any medical bills that may be incurred while I participate in _____ as a student/athlete here at Glendale Community College. I am also aware that there will be a \$100.00 (Football/Soccer) or a \$50.00 (All other sports) deductible. I

_____ understand the above statement and I am aware of my
(Student/Athlete name)
responsibilities as a student/athlete. With this knowledge, I wish to participate in the following competitive sport _____.

MEDICAL INSURANCE INFORMATION

Medical Insurance Name: _____

Medical Claims Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____

Group/Member# _____ Policy# _____

Social Security #: _____

Athlete or Parent Signature: _____ Date _____

ATHLETIC TRAINING FACILITY

WARNING, AGREEMENT TO COMPLY WITH INSTRUCTIONS, **RELEASE, ASSUMPTION OF RISK AND AGREEMENT TO** **HOLD HARMLESS**

I am aware that playing or practicing to play/participate in any sport can be an activity involving **MANY RISKS OF INJURY**. I understand that the risks of playing or practicing to play/participate in the sport listed below include but are not limited to; death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health, and well being. I understand that the dangers and risks of playing or practicing to play/participate in the sport listed below 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.

Because of the risks of participating in the sport below, I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc., and to agree to comply with such instructions.

In consideration of **GLENDALE COMMUNITY COLLEGE** permitting me to try out for (sport)_____ and to engage in all activities related to the team, including but not limited to trying out, practicing or playing/participating in that sport, I hereby assume all the risks associated with participation and agree to hold GLENDALE COMMUNITY COLLEGE, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes or action, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the GLENDALE COMMUNITY COLLEGE (sport)_____ team. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

I acknowledge that I am at least eighteen (18) years of age. If I am less than eighteen (18) years of age, a parent or legal guardian will sign with me.

DATE: _____

(STUDENT'S SIGNATURE)

DATE: _____

(PARENT SIGNATURE)

■ 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 this form 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	

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?		
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 exercise?		
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

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 _____

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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 _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- 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			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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 _____
- ☐ 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 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 or DO

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

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

☐ 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 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 or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____
