COCHISE COLLEGE

# COCHISE COLLEGE ATHLETIC TRAINING POLICIES AND PROCEDURES

Student Athlete Name: _____

Sport: _____ Year at Cochise: 1st 2nd 3rd

Please review all of the forms in this packet. Each of the forms contains information important to the student athlete. Please make sure to print and completely fill out, make sure to sign and date each form in blue or black ink. Return forms to Cochise College Athletic Training Room in the Gymnasium.
Please review the forms for completeness. Incomplete forms or information found to be incomplete are unacceptable. Save a copy for your own records if you are sending the original packet. Student athletes will not be allowed to practice or compete until all of the information is provided.

## COCHISE COLLEGE PARTICIPATION REQUIREMENTS

All participants must receive a preparticipation physical, prior to ANY sport activity including: weight lifting, conditioning, practices and competitions that takes place at any time during preseason, in season or post-season. Physicals are good for one calendar year, from date of exam. All physicals must be current and in good standing for the entire school year. If a student athlete's health insurance changes throughout the year it is his/her responsibility to inform the Cochise College Athletic Training department of these changes and have a copy of the new insurance information.

## Cochise College Athletic Training Staff

Sierra Fultz, EdS, ATC/L
fultzs@cochise.edu
520-417-4124

Maggie Castillo, ATC/L
castillomaggie@cochise.edu
520-417-4723

COCHISE COLLEGE

# COCHISE COLLEGE STUDENT-ATHLETE INFORMATION FORM

## Student Athlete Information

| | | |
|---|---|---|
| Last Name: | First Name & Middle Initial: | Year at Cochise College: 1st 2nd 3rd |
| Date of Birth: | Sport(s): | SS#: |
| Address: | | Phone Number: |
| Allergies: | | |
| Other Medical Conditions (asthma, diabetes, heart condition, sickle cell status, etc): | | |
| Medications (including birth control, and ibuprofen if taking daily): | | |
| Supplements (vitamins, protein, creatine, etc): | | |

## Emergency Contact Information

| | |
|---|---|
| Primary Contact Last Name: | First Name: |
| Phone Number: | Additional Phone Number: |
| Home Address: | |
| City/State/Zip: | |
| Secondary Contact Last Name: | First Name: |
| Phone Number: | Phone Number: |

## Insurance Information

| | |
|---|---|
| Primary Policy Holder: | Policy Holder's SS#: |
| Policy Holder's Date of Birth: | |
| Name of Insurance Company: | |
| Group and/or Policy Number: | Identification Number: |
| Insurance Company Address: | |
| City/State/Zip: | |

## Insurance Card Copy

***Please Attach Card Copy In Assigned Space***

| | |
|---|---|
| FRONT | BACK |

**Cochise College Athletic Department**
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# COCHISE COLLEGE ATHLETE PRE-PARTICIPATION MEDICAL HISTORY

| | | | |
|---|---|---|---|
| Today's Date: | | Sport: | |
| **Athlete Information** | | | |
| Athlete's Full Name: | | | |
| Social Security #: | | Date of Birth: | |
| Permanent Address: | | City/State: | Zip: |
| Home Phone #: | | Cell Phone #: | |
| **Personal Medical History** | | | |
| Have you ever been restricted from participation in physical activity?: | | ☐ YES, Please explain below | ☐ NO |
| Date: | Reason: | | |
| Date: | Reason: | | |
| Do you wear any special protective/corrective equipment to participate in your sport? (ie: braces, goggles/glasses, etc): | | | ☐ YES, Please explain below<br>☐ NO |
| Device: | Please Specify: | | |
| Device: | Please Specify: | | |
| Are you currently taking any Prescribed or Over the Counter medications? (Please include birth control, insulin, allergy shots/pills, asthma inhalers, anti-inflammatories including aspirin, medications for ADD/ADHD, antidepressants, vitamins, nutritional supplements) | | | |
| ☐ NO ☐ YES, Please specify below | | | |
| Name: | | Dosage: | Reason: |
| Name: | | Dosage: | Reason: |
| Name: | | Dosage: | Reason: |
| Do you have any allergies to medications, pollens, foods, stinging insects, etc? | | ☐ YES, Please explain below | ☐ NO |
| Specify: | Explain Reaction: | | |
| Specify: | Explain Reaction: | | |
| Do you have any ONGOING medical conditions for which you have seen a physician on a regular basis? (i.e. diabetes, asthma, etc.) | | | |
| Date Diagnosis: | Condition: | Physician: | Contact #: |
| Date Diagnosis: | Condition: | Physician: | Contact #: |

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## CARDIO-RESPIRATORY MEDICAL HISTORY

| | | |
|---|---|---|
| Have you ever been diagnosed with asthma? ☐ YES ☐ NO | | Do you, or have you, ever used an inhaler? ☐ YES ☐ NO |
| **During or after exercise, have you ever experienced the following?:** | | |
| Dizzy or Light headed, Passed out or Fainted, Chest pain, or Other. | ☐ YES ☐ NO | Please specify: |
| **Have you or anyone in your immediate family been diagnosed with any of the following?:** | | |
| History of heart disease, Heart murmur or Heart Defect, Racing, Irregular or Skipping heart beat | ☐ YES ☐ NO | Please specify: |
| Marfan's Syndrome | ☐ YES ☐ NO | Please specify: |
| High or Low Blood Pressure | ☐ YES ☐ NO | Please specify: |
| Other Heart &/or Vascular problems | ☐ YES ☐ NO | Please specify: |
| **Have you had any medical tests for your heart?** | | |
| EKG, Echocardiogram, or Pulmonary function test, or Other | ☐ YES ☐ NO | Please specify: |

## HEAD AND NEUROLOGICAL MEDICAL HISTORY

| | | |
|---|---|---|
| Have you ever sustained a Concussion | ☐ YES ☐ NO | Please specify/How many?: |
| Have you ever had a loss of consciousness | ☐ YES ☐ NO | Please specify: |
| Long-term problems due to head injury, such as memory loss, headaches, dizziness, &/or nausea | ☐ YES ☐ NO | Please specify: |
| Have you ever sustained a Burner or Stinger | ☐ YES ☐ NO | Please specify: |
| Have you ever sustained a Seizure or Epilepsy | ☐ YES ☐ NO | Please specify: |
| Have you ever sustained a Migraine headache | ☐ YES ☐ NO | Please specify: |

## VISION HISTORY

| | | |
|---|---|---|
| Have you ever had a serious eye injury? | ☐ YES ☐ NO | Please specify: |
| Have you ever had any eye/vision problems? | ☐ YES ☐ NO | Please specify: |

## FEMALE MEDICAL HISTORY

| | | |
|---|---|---|
| Have you ever been diagnosed with stress reaction or fractures? | ☐ YES ☐ NO | Please specify: |
| Have you had Menstrual cramps/pain which affected your school or athletic performance? | ☐ YES ☐ NO | Please specify: |
| Have you had any kidney, bladder, or urinary tract infections within the past 12 months? | ☐ YES ☐ NO | Please specify: |

## MALE MEDICAL HISTORY

| | | |
|---|---|---|
| Do you feel pain or burning with urination? Or experience any blood in your urine? | ☐ YES ☐ NO | Please specify: |
| Have you had any kidney, bladder, or prostate infections within the past 12 months? | ☐ YES ☐ NO | Please specify: |
| Any testicular torsion, pain, or swelling? | ☐ YES ☐ NO | Please specify: |

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## BEHAVIORAL HEALTH HISTORY

| | | |
|---|---|---|
| Have you ever been diagnosed with a mental health disorder? | ☐ YES ☐ NO | Please specify: |
| Do you feel depressed? | ☐ YES ☐ NO | Please specify: |
| Do you cry frequently? | ☐ YES ☐ NO | Please specify: |
| Have you ever been to a counselor? | ☐ YES ☐ NO | Please specify: |
| Do you have any other medical issues, which required the services of a mental health professional? | ☐ YES ☐ NO | Please specify: |

## NUTRITIONAL HISTORY

| | | |
|---|---|---|
| Do you feel that you need to gain or loss weight? | ☐ YES ☐ NO | Please specify: |
| Are you a vegetarian, vegan, fruitarian, raw foodist? | ☐ YES ☐ NO | Please specify: |
| Do you eat red meat? | ☐ YES ☐ NO | Please specify: |
| Do you have or have you ever been diagnosed &/or treated for an eating disorder? | ☐ YES ☐ NO | Please specify: |

**If you have any additional conditions or problems that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so that we may be better able to serve you with our medical care.**

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## ORTHOPEDIC MEDICAL HISTORY

Please indicate if you have sustained any injuries to said body parts.
Please note any diagnostics (X-ray, MRI), surgeries, and diagnosis of said injury.

| | | | |
|---|---|---|---|
| HEAD | ☐ YES ☐ NO | | Please specify: |
| NECK | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| SHOULDER | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| ARM | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| ELBOW | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| FOREARM | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| WRIST | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| HAND | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| FINGERS | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| CHEST | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| SPINE | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| ABDOMEN | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| PELVIS | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| HIP | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| THIGH | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| KNEE | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| LOWER LEG | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| ANKLE | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| FOOT | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |
| TOES | ☐ YES ☐ NO | ☐ LEFT ☐ RIGHT | Please specify: |

**This form will be reviewed by the Cochise College Athletic Training Staff and placed in your permanent medical file at Cochise College. By signing below, I agree that all statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that failure to disclose any or all medical problems and/or accurate medical history relieves Cochise College of any and all liability.**

Athlete Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

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## COCHISE COLLEGE ASSUMPTION OF RISK STATEMENT

***Caution: This is a release of legal rights. Read and Understand prior to signing.***

I am aware that playing and/or practicing in any sport can be a dangerous activity involving *MANY RISKS OF INJURY*. I understand that the dangers and risks of playing and or practicing in any sport include, but are not limited to, death, serious head, neck, and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my own (or my son/daughter) body, general health or well-being. Because of the dangers of participation in any sport, I recognize the importance of following the coach's instructions regarding playing techniques, training rules of the sport, other team rules, and to obey such instructions. All participants have the responsibility to help reduce the chance of injury by executing proper skill techniques of sport. Therefore, all student-athletes must obey all safety rules and regulations, report all physical problems to the athletic trainer and/or coach, follow a proper conditioning program, and inspect personal protective equipment daily.

I have been advised to consult with a medical doctor with regard to my personal medical needs. I hereby affirm that there are no health-related issues or problems that preclude or restrict my participation in this Program. I have obtained all required immunizations, if any. I recognize that the 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 the College to secure whatever treatment is necessary, including the administration of an anesthetic and surgery. The 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 College and me. I agree to pay all expenses relating thereto and release the College from any liability for any actions.

**AFTER READING PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS AND SIGN BELOW TO SHOW THAT THE STATEMENTS HAVE BEEN READ, UNDERSTOOD, AND APPROVED.**

_____ I consent to have my self/son/daughter represent Cochise College in approved activities except those activities excluded by the examining physician or Athletic Training Staff.

_____ In the event of any injury or illness, including an emergency situation, requiring medical attention, I grant permission for any treatment deemed necessary by the Athletic Training Staff or attending physician and also authorize transfer of myself/son/daughter to a qualified medical facility.

_____ I agree not to hold Cochise College or anyone on its behalf responsible for any injury occurring to myself/son/daughter in the proper course of such athletic activities or travel.

_____ I acknowledge and accept that there are risks of physical injury involved in athletic participation which may result in permanent paralysis, mental disability, and death.

_____ I hereby voluntarily assume all risks associated with participation and agree to exonerate and save harmless Cochise College and their agents, servants, and employees, the athletic staff of Cochise College, the physicians and other practitioners of the healing arts treating myself/son/daughter from any and all liability claims, causes of action or demands of any kind and nature whatsoever which may arise by, or in connection with, my participation in any activities to the Cochise College team in which my self/son/daughter is involved.

Athlete or Parent/Legal Guardian Signature: _____ Date: _____

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby release my pertinent medical information to the following:

- Other Athletic Training Staff Members
- Physicians, related to my personal care
- Coaches and other Athletic Staff
- Parents/Legal Guardians/Spouse
- Teammates
- Cochise College Sports Information Media
- Professional teams and Other Colleges and their representatives, after a waiver has been signed for that particular requests
- the NJCAA
- Other CC Administration (as deemed necessary)
- Insurance Company and Agents

I hereby authorize all members of the Cochise Athletic Training Staff and any physicians or health care professionals retained by them to release necessary information, records, and reports regarding my medical history, medical status, record of injury and/or surgery, prognosis, diagnosis, record of serious illness, rehabilitation, and related personally identifiable health information to parties identified above. The information includes injuries or illnesses relevant to past, present, or future participation in athletics at Cochise College.

I understand that if the information being disclosed herein may contain information regarding alcohol/drug abuse or treatment, psychiatric care, sexually transmitted diseases, AIDS or HIV, or Hepatitis B or C testing or results, I agree to their release.

The reason for this disclosure is to advise the parties identified above of the nature, diagnosis, prognosis, or other treatment concerning my medical condition and injuries/illnesses sustained while I am a student-athlete. I understand that the individuals or entities receiving the information may not be health care providers covered by federal privacy regulations, and that the information described above may be disclosed publicly.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for Cochise College. I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act or 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. In understand that once information is disclosed per my authorization/consent, the information is subject to redisclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that Cochise College will not receive compensation for its use/disclosure of the information. I may inspect or copy any information used/disclosed under this authorization. I understand that I may revoke this authorization at any time by notifying in writing to the Head Athletic Trainer, but if I do, it will not have any effect on actions the university took in reliance on this authorization prior to receiving the revocation. This authorization expires six (6) years from the date it is signed.

Athlete Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

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# ALLERGY RISK FORM

- Allergic reactions and anaphylaxis occur at sudden instances, and we may never know we have those allergies. Anaphylaxis is a severe, life threatening allergic reaction that can occur within seconds or minutes after exposure to an allergen.
- Symptoms of Anaphylaxis include skin rash, nausea, vomiting, difficulty breathing and shock. If anaphylaxis is not treated right away, it can result in life threatening consequences.
- Cochise College is committed to identifying related allergies to food, drinks, drugs, plants, and/or stinging insects that may cause allergic reactions.
- Anaphylaxis is treated with immediate administration of Epinephrine and immediate contact of Emergency Medical Services (EMS). Cochise College Department of Athletics is in possession of Epinephrine pens. If signs and symptoms of anaphylaxis are recognized upon any of our student athletes, Cochise College reserves the right to administer Epinephrine immediately to avoid any risk of student athletes going into anaphylactic shock.
- The purpose of this assessment is to determine if you are at risk for potential allergens stemming from certain food, drinks, drugs, plants, and/or stinging insects. It is imperative that you inform Cochise College Athletic Training Staff if you have any related allergies that can cause anaphylaxis.
- If you have allergies to any food, drinks, and/or drugs, you are strongly recommended to notify Cochise College Athletic Training Staff in order to take necessary precautions for you overall health, safety, and wellbeing.
- If student athlete has a prescription to epinephrine, it is recommended that the student athlete order another epinephrine pen to provide for Cochise College's Athletic Training staff so members can have faster access to a proper dosage of epinephrine for you/your son/daughter's safety during their participation.

I, (print name)_____, **DO have** allergies stemming from exposure to: Food, Drugs, Plants, Stinging Insects, Drinks, or Other.

Please list: _____

I,(print name) _____, **do NOT have** any known allergies stemming from exposure to certain foods, plants, drinks, drugs, and/or stinging insects.

I reserve the right for Cochise College to administer Epinephrine if I begin to suffer from anaphylaxis.

Athlete Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

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