Muskegon Community College
221 South Quarterline Road ◆ Muskegon, MI 49442

ATHLETE PRE-PARTICIPATION PHYSICAL EXAMINATION

Please PRINT ALL information legibly

Name: ______________________________________Birth Date:______________Male ☐ Female☐ Cell#:_________________

Local Address:____
Street City State Zip

Permanent Address:____
Street City State Zip

Emergency Contact:____ Phone:___________________________
Name Relationship

Past Medical History

Do you currently have or have you ever had the following conditions *during exercise*:

Unconscious/Blackout	Yes	No	Excessive Chest Pain	Yes	No
Unusual heart beat/skipping	Yes	No	Coughing	Yes	No
Asthma attacks	Yes	No	Excessive Shortness of Breath	Yes	No
Lightheadedness/Dizzy	Yes	No			

Do you currently have or have you ever had any of the following conditions:

High Blood Pressure	Yes	No	Breathing/Emphysema/Asthma	Yes	No
Diabetes/Anemia(s)	Yes	No	Seizures/Epilepsy	Yes	No
Cancer	Yes	No	Heart Murmur/Enlarged Heart	Yes	No
Neck Pain/Spinal Pain	Yes	No	Broken Bones/Dislocations	Yes	No
Hernia	Yes	No	Joint Sprains	Yes	No
Muscle Tears	Yes	No	Allergies (Meds/other)	Yes	No
Heat Stroke/Exhaustion	Yes	No	Loss/Impaired function organs	Yes	No
Mononucleosis	Yes	No	Bleeding Problems	Yes	No
Menstrual Dysfunction	Yes	No	Face/Teeth/Mouth	Yes	No
Frequent Headaches	Yes	No	Nose/Throat	Yes	No
Bladder/Kidney/Colon/Ulcer	Yes	No	Shoulder/Elbow/Hands	Yes	No
Liver/Gall stones/Hepatitis	Yes	No	Lunges/Chest/Bronchitis/TB	Yes	No
Ski Disorders/Rash	Yes	No	Glasses/Contacts	Yes	No
Operations/Surgeries	Yes	No	Eating Disorders	Yes	No
Psychological Disorders	Yes	No	STDs	Yes	No
Abdominal Pain	Yes	No	Appendix/Spleen/Mono	Yes	No
Knees/Ankle/Feet	Yes	No	Other	Yes	No

List details for any yes's from above (if they do not fit on this space then list on Student – Athlete Health Record form):

____

List any medical conditions requiring consistent medication or any conditions not listed above:

____

List ALL medications, supplements, energy drinks, & vitamins you currently take (including asthma & contraceptive):

____

I have answered the above questions to the best of my knowledge truthfully and completely:

Athlete Signature: ____________________________**Date:**_____________**Parent Signature:**____________________________
(Required if student-athlete is under 18 years of age)

Physical Examination to be completed by PHYSCIAN ONLY **Student-Athlete's Name:** ______________________________

{Forms with blanks will NOT be accepted}

Height ________________**Weight** __________________**Pulse** ___________________**B/P** _____________________**Visual Acuity** **L:** ______ _**R:** _______

Wearing Contacts/Glasses ☐Yes ☐ No

Medical Examination	OK	Problem/Issue	Comments
Skin & Scalp			
Head & Neck			
Eyes/Fundus			
Ears, Nose, Throat			
Lymphatic's			
Dental			
Thorax			
Lungs			
Heart: Pericardial activity			
Standing/Supine			
Murmur			
Pulse (Brachial/Femoral)			
Abdomen			
Hernia			
Genitalia			
Neurological			
Marfan's Stigmata			

Orthopedic Examination	OK	Problem/Issue	Comments
Ankle			
Back			
Elbow, Hand, Wrist			
Feet			
Hips & Thighs			
Knee & Legs			
Neck & Shoulders			
Flexibility v. Laxity			
Other			

REFERRAL or F/U PLAN: ☐ ATC ☐ ME/Diagnostic Test: ____

☐ LAB ☐ Medical Records re: ____

☐ X-RAY ☐ OTHER: ____

CLEARANCE:

☐Full Unlimited Participation

☐No Athletic Participation: ____

☐Limited Participation, Restrictions: ____

☐Clearance withheld until:____

Physician's Name Printed: ____MD DO

Physician's Address: ____

(Clinic Stamp must be placed here otherwise physical is not considered complete!)

Physician's Signature: ____ Date: ________________

Valid for 1 year

STUDENT-ATHLETE HEALTH RECORD

Name:____ Date of Birth:_________________________

FAMILY HISTORY

Father's Age:________Father's Health: GOOD FAIR POOR (CIRCLE ONE) Mother's Age:_______Mother's Health: GOOD FAIR POOR (CIRCLE ONE)

Number of Siblings:_________________Ages:____

1. If any of the above are deceased please list who, cause of death, & age at death:

   ____

2. Has anyone in your family ever died suddenly from a heart or lung condition? If yes, please specify the condition, relationship to you, & their age:

   ____

3. Has any of your blood relatives ever had:

Cancer	Yes	No	Heart Disease	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No
Ulcer	Yes	No	Emphysema	Yes	No
Mental Illness	Yes	No	Stroke	Yes	No
Allergies	Yes	No	Other not listed	Yes	No

4. Provide any additional comments about your "past medical history" from the physical examination form:

____

____

____

____

____

____

____

____

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STUDENT-ATHLETE INSURANCE STATEMENT

***PARENTS* SHOULD COMPLETE THIS FORM IF NECESSARY.**

A COPY OF YOUR INSURANCE CARD (FRONT AND BACK) IS ALSO REQUIRED!

NOTE: Failure to provide all information requested will result in claims processing delays.
No athlete will be allowed to compete on a college team unless this form is COMPLETELY filled out.
If you are not covered by your parents insurance, we still need their personal information.
Please print all information.

Name of Athlete:____Sport:____________________

Home Address:____
(permanent) *street* *city, state, zip*

Local Address:____
(if not same as above) *street* *city, state, zip*

Date of Birth:______________________________________Phone:____________________________

Emergency Contact:_________________________________Phone:_____________________________
name and relationship

Father/Guardian:___________________________________

Date of Birth:_____________________________________

Address:____

City,State,Zip:_____________________________________

Father's phone #:__________________________________

Employer:____

Medical Ins. Co.:___________________________________

Policy #:____

Is this plan an HMO or PPO?: yes no

Is pre-authorization required for treatment?: yes no

Is a 2nd opinion required before surgery?: yes no

Mother/Guardian:___________________________________

Date of Birth:_____________________________________

Address:____

City,State,Zip:_____________________________________

Mother's phone #:__________________________________

Employer:____

Medical Ins. Co.:___________________________________

Policy #:____

Is this plan an HMO or PPO?: yes no

Is pre-authorization required for treatment?: yes no

Is a 2nd opinion required before surgery?: yes no

5071 WEST H AVENUE | KALAMAZOO, MI 49009 | 269.381.6630
The Leader in Student and Special-Risk Insurance

AUTHORIZATION TO PERMIT USE AND DISCLOSURE OF HEALTH INFORMATION

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use of disclose of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this Authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

____
Student Name (please print)

____
Student Signature Date

____
Parent Name (please print) Relationship to Student

____
Parent Signature Date

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ATHLETIC DEPARTMENT

MEDICAL CONSENT & ACCEPTANCE OF RISK FORM

The following policy and consent forms will remain valid for one year from the date of signature. The following documentation is to be read carefully. If you are under 18 years of age, your parent or guardian must also sign.

MEDICAL CONSENT

I hereby grant permission to the Muskegon Community College Athletic Training Staff, Team Physicians, and Medical Consultants to render to my son/daughter, or myself, any medical care deemed reasonably necessary. This includes preventive care, first aid, rehabilitation, and emergency care treatment. Also, if deemed necessary, I grant permission for hospitalization.

______________________________	______________________________
PRINT STUDENT-ATHLETE NAME	**SIGNATURE STUDENT-ATHLETE**
______________________________	______________________________
DATE	**SIGNATURE PARENT/GUARDIAN (If under 18 years of age)**

ACCEPTANCE OF RISK AND SHARED RESPONSIBILTY FOR ATHLETIC SAFETY

I understand that passing the pre-participation physical examination does not necessarily mean that I am physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify me from participation. I realize that participation in athletics entails risk of injury, permanent disability, and even death. I understand that I share in the responsibility of minimizing these risks to myself and others by keeping in the best possible condition and by following the advice of the Team Physicians / Consultants, Certified Athletic Trainers, Health Services, and Coaches concerning the prevention, treatment, and rehabilitation of athletic injuries or illnesses. I accept the responsibility of promptly reporting all injuries and illnesses to the Certified Athletic Trainers. I understand that I must provide accurate and honest information regarding my physical condition including all previous history and current medications.

I, the undersigned, have read and fully understand the above acceptance of risk and shared responsibility statement. I acknowledge the fact of these risks, and I am willing to assume responsibility while participating in intercollegiate athletics at Muskegon Community College.

______________________________	______________________________
PRINT STUDENT-ATHLETE NAME	**SIGNATURE STUDENT-ATHLETE**
______________________________	______________________________
DATE	**SIGNATURE PARENT/GUARDIAN (If under 18 years of age)**

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STUDENT - ATHLETE HIPAA AUTHORIZATION FORM

I understand my privacy rights under the federal regulations mandated by the Health Insurance Portability and Accounting Act (HIPAA) and, in waiver of those rights, I authorize Muskegon Community College and Mercy Health Sports Medicine/Athletic Training Staff, including full-time and part-time staff, student interns, and athletic training students, to provide to my parents or guardians, coaches, the staff/personnel of my educational institution, other medical professionals/organizations, and insurance company representatives, any and all information concerning my medical care, injury, rehabilitation, treatment, and health status. This information is to be used for the following purposes: advising appropriate persons of my health or injury status relating to the need for further medical treatment, advising the coaching/educational institution staff of my health and/or injury status and any restrictions on my ability to participate in athletics, and accessing insurance coverage under any policy that may cover the costs of my medical treatment.

This authorization is valid for as long as I participate in athletics at Muskegon Community College. I have the right at any time to withdraw this consent and I understand any such withdrawal must be done in writing to Muskegon Community College's Athletic Department. I understand that any withdrawal of consent will not, however, be effective as to any disclosures that Muskegon Community College and Mercy Health Sports Medicine/Athletic Training staff made in reliance upon this authorization prior to receipt of my written withdrawal of consent. I also understand that the information that is disclosed by Muskegon Community College and Mercy Health Sports Medicine/Athletic Training staff pursuant to this authorization may be re-disclosed by persons/entities who receive any such information.

I understand that it is my choice to sign or not sign this agreement and that I cannot be denied medical treatment for refusing to sign. However, I also understand that by choosing not to sign this document, I will not be able to participate in intercollegiate athletics at Muskegon Community College.

______________________________	______________________________
PRINT STUDENT-ATHLETE NAME	**SIGNATURE STUDENT-ATHLETE**
______________________________	______________________________
DATE	**SIGNATURE PARENT/GUARDIAN (If under 18 years of age)**