



Name _____

Sport _____

**RIO HONDO COLLEGE
Kinesiology, Dance and Athletics**

**ATHLETIC PARTICIPATION, WAIVERS, INSURANCE and MEDICAL CLEARANCE
(Acceptance of Risk, Release and Medical Consent)**

Name of Student- Athlete

Student ID #

The above named student-athlete, having been fully advised of the risks and hazards, inherent in athletic activities, including travel, has permission and approval to participate in such athletic activities and travel conducted by the Kinesiology, Dance & Athletics Division, while enrolled as a student at Rio Hondo College.

The student-athlete voluntarily assumes such risks and hazards and releases the Rio Hondo College District and its employees and agents from any liability to said student-athletes for any injury, death or loss of property in any way arising from enrollment or participation in this class or athletic activity.

In the event of injury or medical emergency, the student-athlete hereby grants the college authorization for any required medical treatment by professional medical personnel as may be available and necessary.

Student Signature (if minor, parent/guardian)

Date

Street Address

Telephone Number

City

State

Zip

Email

Emergency Contact:

1. Name _____ Relationship _____ Telephone _____

2. Name _____ Relationship _____ Telephone _____

Insurance Company: _____ Group #: _____

Name of Insured: _____ Policy #: _____

If the student athlete does not possess medical insurance, please read and sign the following statement: In accordance with the terms of Rio Hondo College Athletic Insurance requirements, full coverage is only available to students **who do not currently possess medical insurance** at this time.

Signature of Student-Athlete (if minor parent/guardian)

Date

The Rio Hondo College athletic insurance policy is an "Excess-Type" policy. The claimant must file claims with their primary insurance, and excess claims will be covered for the limits covered by the college's excess insurance policy. Students (parents/guardians) are responsible for a \$50.00-\$100.00 deductible per injury with Rio Hondo College Athletic Insurance.



Name _____

Sport _____

Medical Authorization Release

The Kinesiology, Dance & Athletics (KDA) Division at Rio Hondo College would like to inform you of your rights as they pertain to medical treatments, injuries and the release of medical information. The sports medicine staff at Rio Hondo College is directly responsible for injury prevention and all health care provisions for the intercollegiate athlete. An appointed Physician and the Certified Athletic Trainers' are directly responsible for all phases of health care in the athletic environment.

All medical information is confidential and will be used by authorized medical staff and trustees which include: Team Physicians, Certified Athletic Trainers, Athletic Training Student Interns, Athletic Director, Dean of KDA, athletic insurance specialist, Head Coach and Equipment Specialists. The medical information used or disclosed will be specific to your current injury or overall health status. Only the minimum necessary information will be released to accomplish the intended purpose.

This authorization will remain in force and active for the duration of your athletic eligibility or until any outstanding insurance claims have been settled. You, the student-athlete, have the right to revoke this authorization at any time in writing. If you choose to revoke this authorization, you will be unable to continue athletic competition at Rio Hondo College. Please understand that any information disclosed to any individuals outside this covered entity may be subject to re-disclosure by the recipient and is no longer protected by this rule.

I, _____ authorize the athletic medical staff and trustees mentioned above, to use my medical information for my personal wellness and the safety of others.

Student-Athletes Name (Print)

Student-Athletes Signature

Date

If minor (parent/guardian signature)

Sport



Name _____

Sport _____

Consent to Treat Minors

Student-Athlete: _____ DOB: _____ Sport: _____

I hereby authorize the Certified Athletic Trainers' at Rio Hondo College to render my minor, medical services, including preventative, rehabilitative and first aid treatment they deem necessary for the overall well being of my child, prior to, during and post participation in their sport. I hereby authorize the Certified Athletic Trainers' at Rio Hondo College to provide my minor, emergency medical services, including transportation to a local medical facility, if deemed necessary. I understand it is the intent of the Certified Athletic Trainers' at Rio Hondo College to uphold and implement only the highest ethical practices in their profession when providing medical services to my minor.

I hereby grant permission to the attending Physician to provide medical services deemed necessary for the overall well being of my minor. This may include an orthopedic evaluation, anatomic palpations, minor medical treatments, x-rays, surgery, and or casting. I understand that if my child sustains an injury, attempts will be made to contact me, or the minor's secondary emergency contact to notify me of my minor's status. I hereby understand, that if medical personnel, is unable to communicate my child's current status with me, I hereby consent for emergent or urgent care to be administered in the best interest of my minor's well being.

I hereby understand that in the event that medical emergency arises that involves my minor; all efforts will be made by Rio Hondo College Athletic Training staff to contact me as soon as possible.

Signature of Parent/Guardian of Minor

Date

Signature of Student-Athlete

Date

CONCUSSION

A fact sheet for student-athletes

What is a concussion?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
 - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

How can I prevent a concussion?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

What should I do if I think I have a concussion?

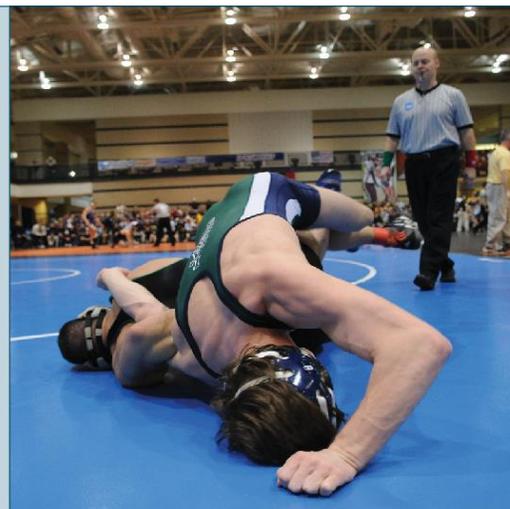
Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion.

Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat



**it's better to miss one game than the Whole season.
When in doubt, get checked out.**

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.



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RIO HONDO COLLEGE ATHLETIC TRAINING

Student-Athlete Concussion Statement

After reading the NCAA Concussion fact sheet, I am aware of the following information (please initial for each):

_____ A concussion is a brain injury, which I am responsible for reporting to my team Physician or
(Initial) Certified Athletic Trainer.

_____ A concussion can affect my ability to perform everyday activities, and affect reaction time,
(Initial) balance, sleep, and classroom performance.

_____ Concussion aren't visual, but I might notice some of the symptoms right away. Other
(Initial) symptoms can show up hours or days after the injury.

_____ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team
(Initial) Physician or Certified Athletic Trainer.

_____ I will not return to play in a game or practice if I have received a blow to the head or body that
(Initial) results in concussion-related symptoms.

_____ Following a concussion, the brain needs time to heal. I understand I am more likely to have a repeat
(Initial) concussion if I return to play before your symptoms resolve.

_____ In rare cases, repeat concussions can cause permanent brain damage, and even death.
(Initial)

I, _____, have read and understand the NCAA Concussion Fact Sheet. I understand it is my responsibility to report all injuries and illnesses to my Certified Athletic Trainer (ATC) and/or team Physician.

Signature of Student-Athlete

Date

Printed name of Student-Athlete

■ 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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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 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 _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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