

Sport _____
Coach _____

RIO HONDO COLLEGE
Physical Education Department

ATHLETIC ACTIVITIES, FIELD TRIP PERMISSION WAIVER and
INSURANCE CLAIMS INFORMATION
(Acceptance of Risk, Release and Medical Consent)

Name of Student

Student ID #

TO WHOM IT MAY CONCERN:

The above named student, having been fully advised of the risks and hazards, inherent in athletic activities and field trips, has permission and approval to participate in such activities and field trips conducted by the Physical Education Department, while enrolled as a student at Rio Hondo College.

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

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

Student Signature (if minor, parent/guardian)

Date

Street address

Home Telephone

City

State

Zip

Cell Telephone

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name _____

Telephone _____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Insurance Company: _____

Group #: _____

Insured Name: _____

Policy #: _____

OR

If student **does not** have medical insurance please read and sign the following statement:
In accordance with the terms of the Rio Hondo College Athletic Insurance Company requirements, full coverage is only available if **I DO NOT HAVE OTHER INSURANCE IN FORCE** at this time.

Signature of Student (if minor parent/guardian)

Date

Rio Hondo College athletic insurance policy is an "EXCESS-TYPE" policy. Claimant must file claims with his/her primary insurance and excess claims will be covered for the limits covered by the college's excess insurance policy. Medical claims not covered by either policy are the athlete's responsibility. Students (parents/guardians) are responsible for a \$50.00-100.00 deductible per injury with Rio Hondo College Athletic Insurance.

Medical Authorization Release Form

The Department of Physical Education and Athletics at Rio Hondo College would like to inform you of your rights as they pertain to treatments, injuries and release of medical information. The sports medicine staff at Rio Hondo College is directly in charge of injury prevention and all health care provisions for the intercollegiate athlete. Under the supervision of Dr. Melvin Coats, 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 medial staff and trustees of the system, which include: Team physician, Head Certified Athletic Trainer, Asst. Certified Athletic Trainer, student athletic trainers, Division Dean, Athletic Director, athletic insurance specialist, asst. athletic specialist, team head coach, team asst. coaches, team equipment attendant. The medical information used or disclosed will be specific to your current injury or overall health status. Only the minimum necessary injury 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 athlete, have the right to revoke this authorization at any time in writing. If you, the athlete, 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 of that system to use my medical information for my personal well-being and safety and the safety of others.

Athletes Name (Print)

Athletes Signature

Date

Sport

Parent Sign (under 18)

Media Press Release Authorization

I, _____ hereby authorize the Rio Hondo College athletic medical staff to release an injury briefing to the campus sports information director and the local press. The injury briefing will consist of the minimum necessary information to accomplish the intended purpose. This briefing will include, but is not limited to: Name, injured area, disposition and current status.

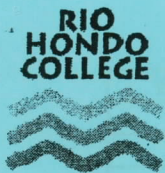
This authorization will remain in force and active for the duration of seven days following initial injury. A copy of this authorization shall be considered as effective and valid as the original.

Athletes Name (Print)

Athletes Signature

Date

Parent Sign (under 18)



Pre-Participation Questionnaire

3600 Workman Mill Road
Whittier CA 90601
Tel (562) 463-7407
Fax (562) 908-3468

Name: _____ Date: ____/____/____
Last First Middle

RHC Campus ID _____ - _____ - _____ Date of Birth ____/____/____

Sport _____ Year (circle): Freshman Sophomore

Address: _____ Home Phone _____ - _____ - _____
Street Apt

_____ Cell Phone _____ - _____ - _____
City State Zip

Family History:

Has anyone in your family had any of the following: **Please circle**

Heart Disease	Yes	No	Diabetes	Yes	No
High Blood Pressure	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Tuberculosis	Yes	No
Sudden Death	Yes	No	Asthma	Yes	No
Epilepsy	Yes	No	Sickle Cell	Yes	No
Migraines	Yes	No	Eating Disorder	Yes	No

If yes, please explain: _____

Personal History:

Do you have or have you EVER had any of the following medical conditions? **Please circle**

High Blood Pressure	Yes	No	Hepatitis	Yes	No	Heat Stroke	Yes	No
Pericarditis	Yes	No	Blood Clots	Yes	No	Heat Exhaustion	Yes	No
Sickle Cell/Carrier	Yes	No	Cancer	Yes	No	Ear Infection	Yes	No
Anemia	Yes	No	Tumor/growth/cyst	Yes	No	Urinary Infection	Yes	No
Diabetes	Yes	No	Bronchitis	Yes	No	Hernia	Yes	No
Chicken Pox	Yes	No	Pneumonia	Yes	No	Mononucleosis	Yes	No
Measles	Yes	No	Asthma	Yes	No	Epilepsy	Yes	No
Mumps	Yes	No	Meningitis	Yes	No	Disordered Eating	Yes	No
Rubella	Yes	No	Migraines	Yes	No	Sexually Transmitted Infection	Yes	No

If yes, please explain: _____

Allergies:

Insect Bites/Stings	Yes	No	Penicillin	Yes	No
Grass/Pollen	Yes	No	Aspirin	Yes	No
Nuts	Yes	No	Anti-inflammatories	Yes	No
Melons	Yes	No	Anti-biotics	Yes	No
Other Foods	Yes	No	Other Medications	Yes	No

Have you ever developed a rash or hives during or after exercise Yes No

If yes, please explain: _____

Mental Health History:

Do you have or have you EVER had any of the following medical conditions? **Please circle**

Attention Deficient Disorder	Yes	No	Panic Attacks	Yes	No
Depression / Unipolar	Yes	No	Phobias	Yes	No
Bipolar / Manic Depression	Yes	No	Personality Disorder	Yes	No
Anxiety Disorder	Yes	No	Paranoia	Yes	No
Obsessive Compulsive Disorder	Yes	No	Post Traumatic Stress Disorder	Yes	No
Eating Disorder	Yes	No			

If yes, please explain: _____

Check the appropriate space according to YOUR use of the following items:

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY
Inhaler				
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives/Diuretics				
Alcoholic Beverages				
Antihistamines				
Allergy Medicine				
Anti-Inflammatories				
Aspirin				
Ibuprofen				
Caffeine				
Coffee/Energy Drinks				
Tobacco				
Protein Supplements				
Amino Acids				
Creatine				

Medical Care:

Have you been hospitalized in the past 12 months? Yes No _____
 Have you had surgery in the past 12 months? Yes No _____
 Are you currently under a doctor's care? Yes No _____
 Are you currently taking any medications? Yes No _____

Neurological:

Have you ever had a head injury/concussion? Yes No _____
 Have you ever been "knocked out"/unconscious? Yes No _____
 Have you ever had a seizure? Yes No _____
 Do you have recurring headaches? Yes No _____

General:

Do you have a history of asthma? Yes No _____
 Are you missing a kidney/lung/testicle? Yes No _____
 Do you have any problems with your vision? Yes No _____
 Glasses/contacts? _____
 Have you had other medical problems? Yes No _____
 (Mononucleosis/anemia/diabetes)
 Do you currently have any skin problems? Yes No _____
 (Itching, rash, blisters, warts, etc.)

Cardiovascular:

Have you ever passed out during/after exercise? Y N
 Have you had chest pain during/after exercise? Y N
 Do you have high blood pressure? Y N
 Have you been told you have a heart murmur? Y N
 Have you ever had a racing heart or a skipped heart beat? Y N
 Has anyone in your family died of heart problems before the age of 50? Y N
 Have you ever had an EKG or echocardiogram? Y N

FEMALE Questionnaire:

Have you ever failed to menstruate for more than 3 consecutive months? Y N
 Do you have irregular cycles (less than 21 days or greater than 35 days apart)? Y N
 Do you have abnormal flow (< 2 or > 7 days)? Y N
 Are you currently on birth control? Y N
 type/name: _____
 Do you take prescription or non-prescription medication for menstrual pain? Y N
 type/name: _____
 Have you had any pregnancies or births? Y N

I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct.

 Student-athlete Signature

 Today's Date

 Parent/Guardian Signature if student-athlete is under 18

 Today's 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.

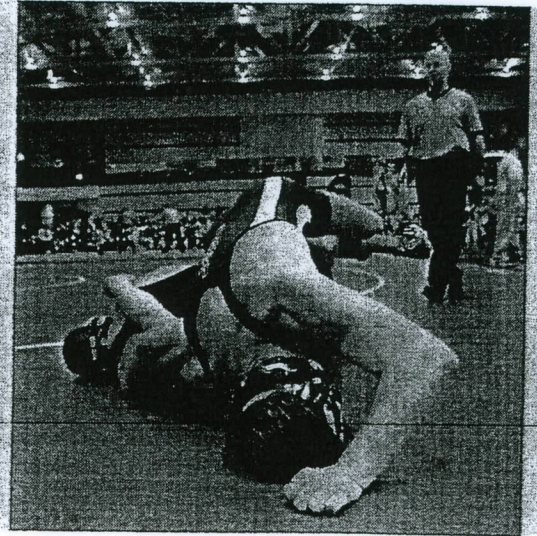
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

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 concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.



**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.



Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.



Physical Examination

3600 Workman Mill Road
Whittier CA 90601
Tel (562) 463-7407
Fax (562) 908-3468

Demographics:

Name: _____ Date: _____
Sport: _____ Gender: Male Female DOB: _____

Physical: ***to be completed by medical staff***

Height: _____ Weight: _____ Pulse: _____ BP: ____/____

Vision: L _____ R _____

Corrected?: Yes No

Allergies: _____

Medications: _____

General Medical Examination:

	Normal	Abnormal
Skin		
Eyes		
Ears		
Nose		
Mouth/Throat		
Lymph Nodes		
Heart/Cardiovascular		
Pulmonary/Lungs		
Abdomen/GI		
Neurological		
Spine		
Shoulders		
Elbows/Wrists/Hands		
Hips		
Knees		
Ankles		

Status:

Qualified _____ Recommendation: _____
Not Qualified _____

Provider Signature: _____ Date: _____

Provider Printed Name: _____

Phone Number: _____

Place Stamp/ Attach Card: