



## Athletic Training Pre-Participation Physical Examination and Waivers

Dear AWC Student-Athlete/Parent:

In anticipation for the upcoming athletics season, this letter is to inform you of the requirements at Arizona Western College to participate in intercollegiate athletics.

Each student-athlete is required to submit:

- Signed medical information policy
  - FYI
    - The certified athletic trainers on staff will only speak to parents/guardians if student-athlete is under 18 years of age or by appointment (phone acceptable) with the student-athlete present.
- Signed athletic accident insurance policy
- If insured, SUBSCRIBERS INFORMATION with legible COPY OF THE FRONT AND BACK OF THE INSURANCE CARD
- Signed concussion policy
- Signed assumption of risk waiver
- Physical completed by a DO, MD, PA-C, or NP
  - FYI
    - Physicals completed by a chiropractor or naturopathic physician are not acceptable.
    - Physicals from a previous institution are accepted if completed within one calendar year.
- Signed medical history

This packet must be filled out **completely** before it is submitted to the athletic training staff. This must be done before participation may begin, including pre-season condition/training.

If you have any questions, feel free to contact the athletic training staff.

Thank you,

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# AWC Athletic Training Medical Information Policy

**This form authorizes Arizona Western College and its personnel to release certain personal information about student-athletes for educational purposes, including information that may be subject to the Family Education Rights and Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Please read it carefully.**

“Personal information” means specific information about you, including education records and personal health information, which Arizona Western College may disclose as a condition to permit you to participate in college intercollegiate athletics; to benefit you in pursuing athletics beyond Arizona Western College; to address your health as you participate in intercollegiate athletics; or to highlight Arizona Western College’s intercollegiate athletics programs or your participation in them. It includes, your name, address, telephone number, date and place of birth, medical or health conditions, major field of study, participation in officially organized activities and intercollegiate athletics-including positions played, weight and height, dates of college attendance, degrees and awards, grade point average, email address, the name of your high school(s), the name of any other postsecondary institution you have attended, your home town. The term also includes any photo, portrait, video clip, or other image of you created by any person on behalf of Arizona Western College.

**By signing this form, I certify that:**

1. I have read and understand the definition of “personal information” specified in this form.
2. I authorize the release of personal information for the purposes specified in this form except those listed here:

\_\_\_\_\_

\_\_\_\_\_

3. I authorize FULL DISCLOSURE of personal information concerning any athletic injury I may sustain while participating in intercollegiate athletics.
4. I understand that some or all of the following persons may be told about my health conditions: coaches, media, parents, athletic director, team physicians, doctors’ staff, referral sources, and the Arizona Western College insurance brokers or companies.
5. I authorize the use and the disclosure of personal information for the following purposes:
  - In promotional literature or video presentations about college athletic programs or about Arizona Western College in general
  - In any Internet website maintained by or for the benefit of Arizona Western College
  - To disseminate to the National Junior College Athletic Association concerning my participation in intercollegiate athletics
  - To include in any program or publication about an athletic event sponsored by Arizona Western College or by any other organization and in which Arizona Western College is participating
  - To disseminate to other postsecondary institutions in connection with their recruitment activities
  - To release to any newspaper, broadcasting entity, or any other media outlet
  - To disseminate to any high school or other educational institution I have attended

I understand that I have the right not to consent to the release of my education records and to receive a copy of them on request. This consent shall remain in effect until revoked by me, in writing, and delivered to Arizona Western College. Any revocation will not affect disclosures that Arizona Western College made before receiving my revocation.

Printed name: \_\_\_\_\_ Sport: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian if under 18: \_\_\_\_\_ Date: \_\_\_\_\_

## **AWC Athletic Accident Insurance Policy**

All student-athletes must complete a current insurance information form, and **must provide a copy of the front and back of their insurance card**. Each student-athlete is responsible for updating his or her personal insurance information, should it change over the course of the year. **Failure to do so may result in the student-athlete incurring all medical expenses**. Arizona Western College serves as the **secondary provider** to any existing coverage for in-season athletic accidental injuries. Any stated pre-existing injuries are to be covered by the athlete's primary insurance. Subscriber's SSN, DOB, and employer information is required if applicable.

In the event of being referred to a physician for an athletic injury your insurance **will be** utilized and they will pay their normal benefits before the school's supplemental accident insurance will pay any benefits. The athletic trainer will assist you with filing a claim with the supplemental accident insurance carrier. It is important to note that all medical bills are the **responsibility of the student athlete**. **It is also the responsibility of the student athlete that all medical claims are properly filed with their own personal insurance carrier and with the school provided supplemental accident insurance carrier**. If a medical claim is not filed properly or the primary insurance carrier's guidelines are not followed the student athlete will be responsible for any and all medical bills. It helps if you bring in all copies of bills, explanation of benefits from all providers and insurance companies to the athletic trainer for review and assistance. Failure to follow through with these requests can lead to failure and delay of any payment for medical treatments and the possibility of the athlete going into collections.

My signature verifies that I understand the accident insurance policy provided by Arizona Western College is a supplemental insurance policy. I also understand that if I do not follow the claim filing procedures set forth by my primary insurance carrier and the school provided supplemental insurance carrier, **I will be responsible for all medical bills**.

Printed name: \_\_\_\_\_ Sport: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian if under 18: \_\_\_\_\_ Date: \_\_\_\_\_

I am NOT covered under a group insurance and/or have NO INSURANCE COVERAGE.

I am covered under the following plan:

**Subscriber's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Relationship to student-athlete:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Subscriber's Employer:** \_\_\_\_\_

**Insurance Co:** \_\_\_\_\_ **Insurance Phone:** \_\_\_\_\_

**Insurance Policy Number:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insurance Type:** HMO  PPO  Other: \_\_\_\_\_

**You must attach a copy of the card (front and back) in order for this form to be complete.**

## **AWC Athletic Training Concussion Policy**

It is the goal of Arizona Western College to provide the best care possible to all students participating in intercollegiate athletics. The following comprehensive concussion policy has been developed in an effort to maintain the highest standard of care in the treatment of cerebral concussion injuries.

### **Concussion Definition**

A concussion is a disturbance in brain function that occurs following either a blow to the head or as a result of the violent shaking of the head which results in a wide range of physical, cognitive, emotional, and/or sleep related symptoms. As described in the NCAA Sports Medicine Handbook, a concussion is a “complex physiological process affecting the brain induced by traumatic biomechanical forces”. While most concussion injuries are a result of a direct blow to the head, a concussion may also result from a force elsewhere to the body that is transferred to the head.

### **Second Impact Syndrome (SIS) Definition**

Second Impact Syndrome (SIS) occurs when an athlete, who has already sustained a head injury, sustains a second head injury prior to complete resolution of symptoms from the first injury (including post-concussion syndrome symptoms). The second injury (even a mild injury) to the head results in the loss of autoregulation of the blood supply in the brain leading to excessive swelling of the brain and increased intracranial pressure causing the brain to herniated through the skull. Second Impact Syndrome occurs when a person has returned to participation too soon and a second injury to the head occurring days or even weeks after the first head injury. It may take days and weeks for concussion symptoms to resolve.

### **Neurocognitive Testing (ImPACT Test)**

While a neuroimaging examination (MRI, CT, EEG) of a concussive injury is important to rule out physical intracranial injury, this examination will not determine the effects of a concussion. The reason for this issue is that concussion is a metabolic rather than structural injury. Thus, structural neuroimaging techniques are insensitive to the effects of concussion.

The ImPACT neurocognitive test is given as a pretest to all athletes in the sports of Football, Softball, Baseball, Men’s/Women’s Soccer, Volleyball, Men’s/Women’s Basketball and the Spirit Squad to provide a baseline measure in case of injury. If injured, athlete will take a 48 hour rest from activity and then if relatively asymptomatic take ImPACT neurocognitive test again for comparative purposes. Post-testing with ImPACT may continue as indicated by physician until results are similar to baseline test.

<b>Common Signs</b>	<b>Common Symptoms</b>
<ul style="list-style-type: none"><li>• Appears to be dazed or stunned</li><li>• Confused about assignment</li><li>• Unable to remember plays</li><li>• Unsure of game, score, opponent</li><li>• Slow to answer questions</li><li>• Moves clumsily</li><li>• Loses consciousness</li><li>• Vomiting</li><li>• Shows behavior or personality changes</li><li>• Can't recall events before the hit</li><li>• Can't recall events after the hit</li></ul>	<ul style="list-style-type: none"><li>• Headache</li><li>• Nausea</li><li>• Dizziness or balance problems</li><li>• Double or fuzzy vision or any other visual alteration</li><li>• Sensitivity to light and/or noise</li><li>• Feeling sluggish or slow</li><li>• Feeling “foggy” or groggy</li><li>• Concentration or memory problems, confusion</li><li>• Extreme fatigue</li></ul>
Observed by Athletic Trainer/Coach/Parent/Official	Felt by athlete

## **Treatment Protocol**

All athletes suspected of sustaining a concussion will follow this treatment protocol without exception.

1. Removal from activity (contest/practice) following signs and symptoms of concussion
2. No return to play in current activity (contest/practice)
3. Medical Evaluation following injury
  - a. Rule out serious intracranial injury
  - b. Neurocognitive Testing
4. Stepwise Return-to-Play Guideline
  - a. No activity and rest until asymptomatic (including post-concussion symptoms)
  - b. Light aerobic exercise (may not begin until Neurocognitive test returns to normal)
  - c. Sport-specific training
  - d. Non-contact drills
  - e. Full-contact drills
  - f. Resume game play
5. Stepwise Return-to-Class Guideline
  - a. No class attendance for 48 hours
  - b. Return to class progressively based on post-concussion symptoms

I recognize this activity does have inherent risks that could result in serious injuries or death. I have read and understand the Arizona Western College Athletic Training Concussion Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian if under 18: \_\_\_\_\_ Date: \_\_\_\_\_

## **Return to Play Protocol**

To ensure the health and safety of student athletes, the certified athletic trainer is a medical consultant for the student athlete's health. In the event an athlete is injured s/he will be referred to the certified athletic trainer(s). The certified athlete trainer(s) will do an assessment and communicate a recommendation to the athlete, coach and, if necessary, the student's healthcare provider. Due to the variance in our medical community and the greater medical community, any medical clearance made by a licensed physician will undergo a guided return to play process with the certified athletic trainer(s). The coach(es) will be informed and involved as needed in the return to play process, but a coach may not be the determining factor to return to activity. The certified athletic trainer(s) is the medical professional representative for Arizona Western College and its student athletes and will make the final decision on return to play status. Return to play status will be communicated to the student athlete orally and the coach through oral and/or written communication.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian if under 18: \_\_\_\_\_ Date: \_\_\_\_\_

**Assumption of Risk and Release of Liability**

I \_\_\_\_\_, freely choose to participate in the athletic program at Arizona Western College. I am aware that participating in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of participating in any athletic activity include, but are not limited to: death; serious neck and spinal injuries which may result in a complete or partial paralysis or brain damage; 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 wellbeing. Because of the aforementioned dangers of participating in athletic activity, I recognize the importance of following all instructions of the coaching staff and/or Athletic Training Department. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics. In consideration of Arizona Western College permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless Arizona Western College; its District Governing Board, employees, and volunteers; and the Matador Athletic Association from any and all liability, any medical expenses not covered by Arizona Western College Athletic Department's accident coverage insurance, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connections with my participation in any activities related to intercollegiate athletics. The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at Arizona Western College.

I hereby attest that I have read and fully understand the Arizona Western College Sports Medicine Department's Medical Examination and Authorization Waiver. Further, I abide by all requirements set forth, and I understand that failure to abide by the requirements could result in unfavorable health consequences.

Printed name: \_\_\_\_\_ Sport: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian if under 18: \_\_\_\_\_ Date: \_\_\_\_\_

## AWC Sports Medicine Physical Examination Form

Name: \_\_\_\_\_ Sport: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Class: Fresh / Soph SSN#: \_\_\_\_\_ Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_  
Permanent Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email (Toro preferable): \_\_\_\_\_ Student ID: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

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(To be filled out by a physician)

### **Physical Examination:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_ Respiration: \_\_\_\_\_  
Vision: R \_\_\_\_\_ L \_\_\_\_\_ Contacts Y/N \_\_\_\_\_ Hearing: R \_\_\_\_\_ L \_\_\_\_\_  
Immunizations: DIP/TE \_\_\_\_\_ (date) MMR \_\_\_\_\_ (date)

#### **General**

\_\_\_\_ Head/Scalp  
\_\_\_\_ Eyes/Pupils  
\_\_\_\_ Nose/Sinus  
\_\_\_\_ Throat/Pharynx  
\_\_\_\_ Thyroid  
\_\_\_\_ Lymph Nodes  
\_\_\_\_ Heart Conditions  
\_\_\_\_ Chest/Lungs  
\_\_\_\_ Spleen  
\_\_\_\_ Liver  
\_\_\_\_ Abdomen  
\_\_\_\_ Hernial Rings  
\_\_\_\_ Genitalia  
\_\_\_\_ Inguinal Nodes  
\_\_\_\_ Skin  
\_\_\_\_ Nailbeds – Fingers / Toes

#### **Orthopedic**

\_\_\_\_ Neck  
\_\_\_\_ Jaw  
\_\_\_\_ Shoulders  
\_\_\_\_ Elbows  
\_\_\_\_ Wrists  
\_\_\_\_ Fingers  
\_\_\_\_ Spine  
\_\_\_\_ Ribs/Sternum  
\_\_\_\_ Pelvis  
\_\_\_\_ Hips  
\_\_\_\_ Knees  
\_\_\_\_ Ankles  
\_\_\_\_ Feet/Toes

### **Musculoskeletal:**

Upper Extremity: R \_\_\_\_\_ L \_\_\_\_\_  
Lower Extremity: R \_\_\_\_\_ L \_\_\_\_\_  
Back: \_\_\_\_\_ Torso: \_\_\_\_\_  
Gait Pattern: \_\_\_\_\_

### **Neurological:**

Reflexes: \_\_\_\_\_ Atrophy: \_\_\_\_\_ Paralysis: \_\_\_\_\_

### **Cardiovascular:**

Murmurs (auscultation standing, supine, +/- Valsalva) Normal: \_\_\_\_\_ Abnormal Findings: \_\_\_\_\_  
Location of point of maximal impulse (PMI) Normal: \_\_\_\_\_ Abnormal Findings: \_\_\_\_\_  
Are other Tests/Exams needed? Yes \_\_\_\_\_ No \_\_\_\_\_ What? \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Athletic Participation Clearance:**

- Cleared
  - Cleared after completing evaluation/ Rehabilitation for \_\_\_\_\_
  - Not Cleared for:
    - Collision
    - Contact
    - Non-contact
- Due to: \_\_\_\_\_

Examining Physician: \_\_\_\_\_ MD, DO, NP, PA-C Date of Exam: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

# AWC Sports Medicine Medical History

## Athlete History

Have you had or ever been treated for, please provide the DATE AND DETAILS:

- Head Injury/Concussion       NO  YES (Details: \_\_\_\_\_)
- Bell Rung       NO  YES (Details: \_\_\_\_\_)
- Neurological Problem/Disorder       NO  YES (Details: \_\_\_\_\_)
- Dizzy Spells/Fainting       NO  YES (Details: \_\_\_\_\_)
- Vision Problems/Loss       NO  YES (Details: \_\_\_\_\_)
- Heat Illness/ Dehydration       NO  YES (Details: \_\_\_\_\_)
- Muscle Weakness       NO  YES (Details: \_\_\_\_\_)
- High/Low Blood Pressure       NO  YES (Details: \_\_\_\_\_)
- Anemia       NO  YES (Details: \_\_\_\_\_)
- Blood Disorder/Hemophilia/Sickle Cell Trait       NO  YES (Details: \_\_\_\_\_)
- Heart Trouble/Chest Pain       NO  YES (Details: \_\_\_\_\_)
- Kidney/Bladder Problems       NO  YES (Details: \_\_\_\_\_)
- Ulcers/Stomach Trouble       NO  YES (Details: \_\_\_\_\_)
- Hepatitis       NO  YES (Details: \_\_\_\_\_)
- Tuberculosis       NO  YES (Details: \_\_\_\_\_)
- Measles       NO  YES (Details: \_\_\_\_\_)
- Epilepsy/Seizures       NO  YES (Details: \_\_\_\_\_)
- Diabetes       NO  YES (Details: \_\_\_\_\_)
- Allergies/Hay Fever       NO  YES (Details: \_\_\_\_\_)
- Pneumonia/Bronchitis       NO  YES (Details: \_\_\_\_\_)
- Asthma/Exercise Induced Asthma       NO  YES (Details: \_\_\_\_\_)
- Menstrual Problems       NO  YES (Details: \_\_\_\_\_)
- Hernia - Sports/Inguinal/abdominal       NO  YES (Details: \_\_\_\_\_)
- Addiction to Drugs/Alcohol       NO  YES (Details: \_\_\_\_\_)
- Mental Illness/Nervous Breakdown       NO  YES (Details: \_\_\_\_\_)
- Bone/Joint Disorder       NO  YES (Details: \_\_\_\_\_)
- Joint Dislocation       NO  YES (Details: \_\_\_\_\_)
- Fracture       NO  YES (Details: \_\_\_\_\_)
- Surgery       NO  YES (Details: \_\_\_\_\_)

Have you ever been hospitalized?  NO  YES If so, why? \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_

Are you **allergic to any medications**? \_\_\_\_\_

## Family History:

Has anyone in your immediate family experienced, please write who (i.e. maternal grandmother) next to answer:

- Heart Attack:       NO  YES  NOT SURE \_\_\_\_\_
- High Blood Pressure:       NO  YES  NOT SURE \_\_\_\_\_
- Circulatory Disorder:       NO  YES  NOT SURE \_\_\_\_\_
- Heart Disease:       NO  YES  NOT SURE \_\_\_\_\_
- Diabetes:       NO  YES  NOT SURE \_\_\_\_\_
- Asthma:       NO  YES  NOT SURE \_\_\_\_\_

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

Signature of athlete: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian if under 18: \_\_\_\_\_ Date: \_\_\_\_\_