Name_______________________

Sport(s)_______________

Date of Birth____/____/____

Minor? Yes ☐ No ☐

If yes, minor until (give date)

___/___/___

Checklist for Participation in Intercollegiate Athletics

Dear Student-Athlete (and Parent/Guardian if minor),

Attached to this Checklist you will find the documentation needed for you (or your child) to participate in Intercollegiate Athletics at Gavilan College. Please read **ALL** information completely. **ALL** forms **MUST** be filled out **PRIOR** to participation during in-season practice and competition, and non-traditional competition.

***Please use the following checklist as a guideline. Failure to complete any one of these documents in their entirety will result in a delay of clearance by the Sports Medicine Team and you (or your child) will not be allowed to participate until all documentation has been completed.**

☐ **Page 1:** Emergency Contact/Insurance Information and Consent to Treat

☐ **Page 2:** Warning Agreement to Obey Instruction, Release Assumption of Risk, Agreement to Hold Harmless and Consent to Treat

☐ **Pages 3-5**: Student-Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injury and Illness

☐ **Page 6:** If you are a minor, a parent or guardian must fill out the ImPACT permission form for concussion baseline testing.

☐ **Page 8-9:** Pre-Participation Personal and Family Medical History **to be reviewed with Doctor conducting PPE.**

☐ **Page 10:** The Medical Doctor or Doctor of Osteopathic Medicine must **fill out, sign, date, and stamp** the final page of the Physical examination packet. Their **name and title must be legible**. If one of these things is not completed, the physical will not be valid and verification from the treating physician's office will be necessary for clearance.

☐ Provide a copy of the front and back of your (or your child's) medical insurance card.

To be completely cleared by the sports medicine staff, the athlete must complete concussion baseline testing with the Athletic Trainer. There will be sessions scheduled prior to the start of season that the athlete must sign up for. Dates and times are TBD, your coach will let you know.

The completion of this checklist will make you (or your child) eligible for participation in Gavilan College Athletics from a Sports Medicine standpoint only. ***Final clearance and certification is determined by the Dean of Kinesiology & Athletics and will be communicated to each head coach.***

If you have any questions, please let your coach know, or you can contact the Athletic Trainer at (408)848-4877.

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Gavilan College Sports Medicine
Emergency Contact / Insurance Information

SPORT(s):__________

NAME: **DATE OF BIRTH:**

YEAR: (Freshman / Sophomore) **SSN:** **No SSN (initial ____)**

LOCAL ADDRESS: **CITY:** **STATE:** **ZIP CODE:**

PHONE NUMBER: (H) **(C)** **(W)**

E-MAIL

Emergency Contacts

Mother's name: **Phone Number:** (H) (C) (W)

Father's name: **Phone Number:** (H) (C) (W)

List Two Emergency Contacts OTHER THAN YOUR PARENTS

Name	Relationship	Phone Numbers		
		(H)	(C)	(W)
		(H)	(C)	(W)

Insurance Information

Do you have health insurance? YES NO **Are you an International Student?** YES NO

Primary Coverage is through: ☐ Parent ☐ Self ☐ Spouse

Type of Coverage through: ☐ Individual ☐ Employer **Employer Name**(if applicable):

Type of Coverage: ☐ **HMO** ☐ **PPO** ☐ **Medi-CAL**

Policy Number: **Group Number:** **Member Number:**

Policy Holder's Name: **Relationship:** **SSN:**

Insurance Company Name: **Phone Number:**

Insurance Company Address:

Primary Care Physician's Name: **Phone Number:**

Preferred Hospital (name and address):

Emergency Information

Are you currently taking any medications? No Yes: (list)

Are you allergic to any medications? No Yes: (list)

Do you have any known allergies? No Yes: (list)

I certify that all the information is correct. In the event of any illness or injury, I hereby consent to any emergency transportation needed in the case of a medical emergency and whatever e-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care from a licensed Physician and/or Surgeon as deemed necessary for my safety and welfare.

Signature of Student- Athlete ____ Date_______________

Signature of Parent/Guardian (if under 18)________________________________ Date______________

GAVILAN COMMUNITY COLLEGE DISTRICT

WARNING AGREEMENT TO OBEY INSTRUCTIONS, RELEASE ASSUMPTION OF RISKS, AGREEMENT TO HOLD HARMLESS AND CONCENT TO TREATMENT

SPORT(S): ____

I am aware that playing or practicing to play/ participate in any sport can be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of playing or practicing to play/ participate in the above sports include, but are not limited to: death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, 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 well being. I understand that the dangers and risks of playing or practicing to play/ participate in the above sport may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life.

Because of the dangers of participating in the above sport(s), I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc., and to agree to obey such instructions.

In consideration for the Gavilan Community College District permitting me to participate in Varsity ______________________ (indicate sport) team and to engage in all activities related to the team, including but not limited to practicing or playing/participating in the sport, I hereby assume all risks associated with the participation and agree to hold Gavilan Community College District, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the Varsity _____________________team. The terms hereof shall serve as a release and the assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

Unless otherwise advised, I understand that I am responsible for my own transportation to and from the activity(ies) and the district assumes no liability for loss or injury resulting from my transportation. Although the district may assist in coordinating and providing the transportation any assistance and/or recommendations provided is not mandatory. If the district is providing transportation but I do not use the transportation, I am responsible to make my own transportation arrangements and the district assumes no responsibility or liability of any kind.

I give permission for the Host Certified Athletic Trainer(s) to evaluate, provide necessary treatment and/or referral to a physician for any injuries or illnesses that occurs as a result of my participation on an intercollegiate athletic team offered through the Gavilan Community College District. This participation may include practices, competition and/or traveling with an intercollegiate athletic team at Gavilan College.

I acknowledge that I have carefully read this **WARNING AGREEMENT TO OBEY INSTRUCTIONS, RELEASE ASSUMPTION OF RISKS, AGREEMENT TO HOLD HARMLESS AND CONCENT TO TREATMENT** form and I understand and agree to its terms.

____

Student-Athlete Name (please print) Student-Athlete Signature Date

***<u>If Student-Athlete is under the age of 18, please have parent or guardian sign below</u>*:**

____

Parent or Guardian Name (please print) Parent or Guardian Signature Date

The above information parallels the statement of the NCAA Committee of Competitive Safeguards and Medical Aspects of Sports.

Student-Athlete Authorization/Consent for Disclosure of Heath Information Regarding Athletic Related Injuries and Illnesses.

Background:
This consent form is designed to inform you of the public nature of your athletic injuries and illnesses and obtain your consent to our release of certain personal health information.

Participating in varsity intercollegiate sports by its nature puts an athlete in the public eye. Both television and print media may be following and reporting on the team and sometimes on individual athletes. They are often interested in illnesses or injuries that will result in missed game time or limit performance.

As a varsity athlete you enter into an agreement with the Athletic Department with unique rights and responsibilities as described in the Student-Athlete Handbook. Sharing medical information about your injuries or illnesses with coaches and other Athletic Department administrators is helpful (such as when a coach is planning a roster for an upcoming competition) and sometimes necessary (such as when applying for a “medical redshirt”). Personal health information must be sent to the Coast Conference and/or California Community College Athletic Association (CCCAA) when applying for a medical redshirt.

Often other athletes are within hearing distance while you are being treated in the Athletic Training room or on the field for your athletic injuries and illnesses.

Lastly, concerned parents often request information about your care for athletic injuries and illnesses.

Definitions:
Athletic injuries and illnesses: This may refer to and injury or illness that impacts your ability to play and/or perform for Gavilan College’s varsity intercollegiate sports. Medical information that will not be released includes information about psychological/psychiatric illness, substance abuse, eating disorders, obesity, sexually transmitted disease, neuropsychiatric testing, or learning disabilities. If a four-year institution requests information about your *athletic injuries and illnesses* we will release such information to the team ONLY if you give us specific written consent.

Sports Medicine Staff: This refers to all persons working under the direction of the Team Physician and/or Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, student athletic trainers, and administrative assistant for medical billing.

Gavilan College Sports Medicine

Student-Athlete Authorization/Consent for Disclosure of Heath Information Regarding Athletic Related Injuries and Illnesses.

Consent:

I, ______________________________, acknowledge that I have read and understand the
Name of Student-Athlete

Background and Definitions above and that

I, ______________________________, hereby authorize Gavilan College and its *sports*
Name of Student-Athlete

medicine staff (physicians, athletic trainers and health care personnel) to disclose when requested or necessary my protected health information and any related information regarding my *athletic injuries and illnesses* to the following groups/persons:

List A: Group/Persons
Gavilan College Athletic Department Administrators including but not limited to coaches, athletic director, and public information office
Teammates or other varsity athletes
Parents or guardians
CCCAA and its employees or agents

I understand that the information released may have different purposes and is dependent on to whom the information is releases. These purposes may include but are not limited to:

List B: Purposes
Athletic Department operations
Answering media questions
Explaining the typical course of an injury or illness to another athlete
Informing concerned parents or guardians
Asking the CCCAA to grant a medical redshirt (hardship) or exemption

I understand that my injury/illness information is protected by federal regulations under wither the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for

Student-Athlete Authorization/Consent for Disclosure of Heath Information Regarding Athletic Related Injuries and Illnesses.

this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in CCCAA or conference athletics.

I also understand that the media outlets, Coast Conference; CCCAA, parents and guardians, and other varsity athletes are not covered by the Buckley Amendment or HIPAA and that this policy does not apply to their use or disclosure of my *athletic injury and illness* information.

This authorization/consent expires in 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the Head Athletic Trainer at Gavilan College. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Student-Athlete Name Student-Athlete Signature Date

If the Student-Athlete is under the age of 18, the parent or Guardian must also sign below:

Parent or Guardian Name Parent or Guardian Signature Date

Dear Parent/Guardian,

Gavilan College is currently implementing an innovative program for our student-athletes. This program will assist our team physicians/athletic trainers in evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to the treating physician, to help evaluate the injury. The information gathered can also be shared with your family doctor. The test data, along with a physical examination, will enable these health professionals to determine when implementation of the return-to-play protocol is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The Gavilan College administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program please feel free to contact the Sports Medicine Staff at (408) 848-4877.

Sincerely,

The Sports Medicine Staff

~~~~~~

Consent

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the information above. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

Printed name of Athlete___________________________________ Sports ____________________________

Signature of Athlete__________________________________ Date__________________________

Printed name of Parent _______________________________

Signature of Parent___________________________________ Date__________________________
~~~~~~

Gavilan College Pre-Participation Examination Directions

Dear Student-Athlete/Guardian & Physican,

Welcome to Gavilan College Athletics. Before being able to practice or compete with any of our teams, students are required to complete and pass a pre-participation physical examination. The exam must be signed off by and certified (official medical office stamp) by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO). Pre-participation examinations signed off and certified by Nurse Practitioners, Physician's Assistants, Chiropractors, Acupuncturists, Authorized Signer or any other health care practitioner **will not be accepted**. This exam enables the Sports Medicine staff to best serve the needs of the student so that he or she can participate safely and effectively.

The pre-participation exam consists of three pages. You need to take your time and make sure that you complete all the information as completely and accurately as possible. It is also important that the physician performing the exam do the same. To help you, the student-athlete/guardian and the physician performing the exam, below are some helpful directions. Please show these to your physician:

Student-Athlete/Guardian

- At the top of all three pages, please make sure that you print neatly your **last name, first name, and all the sports you will be playing.**
- Please take your time and answer all the questions, you should either check Yes or No for the questions asked. If you check 'Yes', an explanation is needed. Please use the space provided to elaborate. **Failing to answer all questions will result in you not being able to practice or compete in a timely manner.**
- On Page 8, you need to fill out and answer all the questions listed on that page.
- On Page 9, you need to fill out and answer all the questions listed on that page.
- At the bottom of Page 9, sign and date certifying that all the information on all the pre-participation examination forms (including family, medical, and my history), filled out by you, are complete and accurate to the best of your knowledge. If you are under the age of 18, your parent or guardian must sign and date as well.
- On Page 10, you need to provide your name and sport. **Do not complete Page 10.** That is for the MD or DO to fill out.

Physician (MD or DO)

- After reviewing the Medical and Musculoskeletal History information located on Page 8 and Page 9, please perform the medical and musculoskeletal examination on Page 10, giving the details in the space to the right if anything is abnormal or noteworthy.
- Please note any findings and then check the box with the appropriate medical and musculoskeletal disposition.
- You would then need to **print and sign your name along with the date at the bottom of the form.**
- **Also, please indicate if you are a MD or DO and have your office stamp placed at the bottom of the form.**

After completing the screening, the student should return all three pages to the Athletic Trainer. If the student wants a copy of the screening exam, they should make a photocopy before submitting the originals. Thank you in advance for your diligence in completing this process.

If you have any questions, please contact Rebecca Northon in the Gavilan College Athletic Training Room: (408)848-4877

Gavilan College Sports Medicine
Medical History

Print Last Name:________________________________ First Name:___________________________ Sport(s):__________

This Exam must be signed off by an MD or DO

Exams signed off by any other health care professional will not be accepted!
Students must complete all pages of the Pre Participation Examination. All questions must be answered.
MD or DO must complete and sign the Physical portion of this packet

1 FAMILY MEDICAL HISTORY: Check "Yes" or "No" for all questions and explain all "Yes" responses in the space provided.

- ☐ Yes ☐ No Has anyone in your family ever died for no apparent reason? Relationship to you: ____________________
- ☐ Yes ☐ No Has any family member/blood relative died of heart problems or of sudden death before age 50? Relationship to you: ______________
- ☐ Yes ☐ No Do you have a heart implant or monitor? If yes, describe: ____
- ☐ Yes ☐ No Has anyone in your family had a heart problem/condition and/or surgeries such as, but not limited to: *Check all that apply, if known*

☐ Coronary Artery Disease	☐ Heart Attack	☐ Heart Murmur	☐ Near Fainting/Fainting/Passing out
☐ Skipped Heart Beats	☐ Chest Pain	☐ Bypass Surgery	☐ Shortness of Breath/Excessive/Unexplained
☐ Extra Heart Beats	☐ Heart Defect	☐ Heart Palpitations	☐ Irregular Heart Rhythm/Arrhythmia
☐ Dialated Cardiomyopathy	☐ Angina	☐ Balloon Angioplasty	☐ Excessive Fatigue Associated with Exercise
☐ Hypertophic Cardiomyopathy	☐ Diabeties	☐ High Blood Pressure	☐ Asthma
☐ Marfan's Syndrome	☐ Other: ______________		☐ Other: ______________

2 ATHLETE'S MEDICAL HISTORY: Check "Yes" or "No" for all questions and explain all "Yes" responses in the space provided.

- ☐ Yes ☐ No Have you ever had a medical illness/injury/surgery that kept you from participating in practice or competition? If "yes" explain below:
  Injury/Illness/Surgery was ____________________ Year__________ Amount of time missed: Days______Weeks_____ Months___
- ☐ Yes ☐ No Are you allergic to: ☐ Foods ☐ Stinging Insects ☐ Medications ☐ Environmental agents/pollen:
  List: ____
- ☐ Yes ☐ No Do you use or have you ever used recreational drugs? ☐ Never ☐ Daily ☐ Once/week ☐ More than once/week ☐ Once/month
- ☐ Yes ☐ No Do you ☐ Smoke ciarettes, ☐ dip/chew tabacco? ☐ Never ☐ Daily ☐ Once/week ☐ More than once/week ☐ Once/month
- ☐ Yes ☐ No Do you use or have you ever used alcoholic drinks? ☐ Never ☐ Daily ☐ Once/week ☐ More than once/week ☐ Once/month
- ☐ Yes ☐ No Have you ever passed out or nearly passed out **DURING or AFTER** exercise? Why? ☐ Medical Illness ☐ Conditioning ☐ Heat related
- ☐ Yes ☐ No Are you happy with your weight? If not, what is your ideal weight? __________ lbs
- ☐ Yes ☐ No Do you get more easily tired or fatigued than your teammates during or after exerciese? ☐ Illness ☐ Conditioning ☐ Heat related
- ☐ Yes ☐ No Have you ever had chest discomfort, pain or pressure during exercise? ☐ Mild Exercise ☐ Moderate Exercise ☐ Strenuous Exercise
- ☐ Yes ☐ No Has a Doctor ever ordered or have you had a test for your heart? ☐ EKG ☐ Halter Monitor ☐ Echocardiogram ☐ Stress echo
- ☐ Yes ☐ No Have you ever been hospitalized, had surgery recommended or had surgery for a medical condition?
  If yes, why and when? ____
- ☐ Yes ☐ No Were you born without or are you missing any of the following: ☐ Kidney ☐ Eye ☐ Testicle ☐ other organ: ______________
- ☐ Yes ☐ No Have you ever had a head injury or concussion? How may have you had? ________ When was you last one?_________________.

Yes	No	Medication/Supplement Use	Name of Medication	Reason/Condition	Name of Medication	Reason/Condition
		Over the counter medications				
		Prescription medication/pills				
		Inhalers				
		Supplements (ie Creatine)				
		Weight loss medications				
		Laxatives/Diet Pills				
		Anabolic Sterioids/HGH				
		Birth Control Pills				
		Topical ointments/creams				
		Other:				
		Additional:				

WOMEN ONLY

☐ Yes ☐ No Are you pregnant? How many months?___________.
Date of first menstrual cycle: Month_________Year___________.
Longest time between periods: Days_________Months__________.
No Periods since: Month__________ Year____________.

Immunizations (if known) — **Year**

				Year
☐ unknwn	☐ Yes	☐ No	Tetanus	________
☐ unknwn	☐ Yes	☐ No	Hepatitis A	________
☐ unknwn	☐ Yes	☐ No	Hepatitis B	________
☐ unknwn	☐ Yes	☐ No	Hepatitis C	________

Gavilan College Sports Medicine
Medical History

Print Last Name:____________________ First Name:____________________ Sport(s):__________

2 **ATHLETE'S MEDICAL HISTORY** (con't): Have you ever had any of the following symptoms or medical conditions?

Yes	No	Year	Condition	Yes	No	Year	Condition	Yes	No	Year	Condition
			Chest Pain				Chest Tightness				Bronchitis/ Chronic Bronchitis
			Dizzyness				Chest Pressure				Dilated Cardiomyopathy
			IHSS				High Cholesterol				Hypertrophic Cardiomyopathy
			Rheumatic Fever				Heart Murmur				Shortness of Breath
			Heart Infection				Irregular Heart Beats				Long QT Syndrome
			Asthma/EIA				Heart Skips Beats				Marfan's Syndrome
			Wheezing				High Blood Pressure				☐ Fainting ☐ Nearly Fainting
			Pneumonia				Pneumothorax				Sickel Cell ☐ Trait ☐ Disease
			Ulcers				Cancer				Severe Dehydration
			Heat Cramps/Illness				Heat Stroke				Diabetes ☐ Type 1 ☐ Type 2
			Anemia				Abdominal Pain				Blood Sugar ☐ High ☐ Low
			Headaches				Migraine Headaches				Concussion/Knocked Out
			Seizures				Skull Fracture				Hepatitis: ☐ A ☐ B ☐ C
			Mononucleosis				Anorexia/Bulimia				☐ HIV ☐ Aids
			Hernia				Kidney Disease				Menstrual Irregularity/Cramps
			Appendectomy				Pregnancy				Bladder/Bowel Problems
			Impetigo				Folliculitis				Tinea Corporis (ringworm)
			Herpes Zoster				Tinea Cruris (jock itch)				Herpes Simplex (cold sore)
			Hearing Impairment				Vision Impairment				MRSA
			Thyroid Disease				Jaundice				Crohn's Disease
							Hemophilia				

3 **MUSCULOSKELETAL HISTORY:** Have you ever had any of the following injuries, surgeries, tests or used orthopedic supports for injuries?

Yes	No	Year	Injury	Explain	Yes	No	Year	Injury	Explain
			Muscle Strain/Pull					☐ Knee Pain ☐ Surgery	
			Ligament Sprain					Painful Kneecap	
			Deep Bruise/Contusion					Knee gives way or buckles	
			Joint Locking or Catching					☐ Hip Injury ☐ Surgery	
			☐ Torn Labrum ☐ Torn Cartilage					☐ Shoulder Injury ☐ Surgery	
			Tendonitis/Tedinopathy					☐ Elbow Injury ☐ Surgery	
			☐ Fracture ☐ Stress Fracture					☐ Wrist Injury ☐ Hand Injury	
			☐ Nerve Injury ☐ Stinger					☐ Finger Injury ☐ Thumb Injury	
			☐ MRI ☐ CT Scan for:					Other Orthopedic Surgery for:	
			☐ Bone Scan ☐ EMG for					Neck Pain/Injury	
			☐ Crutches ☐ Sling for:					Arm/Finger Numbness	
			☐ Splint ☐ Cast for:					Arm/Hand Weakness	
			☐ Foot Injury ☐ Toe Injury					Upper Back Injury	
			☐ Ankle Injury ☐ Achillies Injury					Lower Back Pain/Injury	
			Shin Splints/PTSS					Leg/Foot Numbness	
			Unable to participate from Injury					Leg/Foot Weakness	
			Rib/Chest Injury					Hemo/Pneumothorax	
			Skull Fracture/Injury						

Use the following space provided to elaborate on any prior mentioned injuries or medical history: ____________________

____

____

____

I certify that all the information on all the pre-participation Medical History exam forms, I have filled out, including my family medical history, my medical and musculoskeletal history are complete and accurate to the best of my knowledge:

Athlete's Signature ____________________ Date __________

Parent's signature (if Athlete is a minor under 18 y/o): ____________________ Date __________

Sport(s):______________________________________.

Name:__________________________________ Date of Birth: ___/___/____ Height:______*inches* Weight:________*lbs*

Last, First

Eye test: *R* __________ *L* __________ Blood Pressure: _____/______ Resting Heart Rate:__________*BPM*

MD or DO must certify and sign off this section. Doctor, please check each item with your finding and provide a final disposition at the bottom of the form.

MEDICAL EXAMINATION INDICATORS	NORMAL	ABNORMAL FINDINGS/COMMENTS
General Appearance		
Head/Neck		
Hernia (abdominal/inguinal)		
Eyes/Sclera/Pupils		
Ears		
Gross Hearing		
Nose/Mouth/Throat		
Lymph Glands		
Cardiovascular (murmur, rhythm, rate)		
Femoral Pulses		
Lungs: Auscultation/Percussion		
Chest Contour		
Skin		
Abdomen (liver, spleen, masses)		
Assessment of physical maturation or Tanner Scale		
Testicular Exam (Males Only)		

MUSCULOSKELETAL EXAMINATION INDICATORS	NORMAL	ABNORMAL FINDINGS/COMMENTS
Gait		
Cranial Nerves		
Neurological: Balance & Coordination		
Neck/Back/Spine: (deformity, tenderness, motion, strength, stability)		
• **Cervical** (facet dysfunction, disk injury, radiculopathy, stingers)		
• **Thoracic** (kyphosis, scoliosis)		
• **Lumbar** (spondylolisthesis, facet dysfunction, disk injury)		
Upper Extremities: (deformity, tenderness, motion, strength, stability)		
• **AC/SC joint/Clavicle** (AC separation, clavicle instability)		
• **Shoulder** (RC, labrum, instability, impingement)		
• **Elbow** (UCL, tendonitis, loosebodies, tendonitis)		
· **Wrist/Hand** (carpal tunnel, tendinitis, instability)		
· **Thumb** (instability, tenderness, motion,		
· **Fingers** (Mallet/Jersey finger, Swan Neck/Boutineer deformity)		
Lower Extremities: (deformity, tenderness, motion, strength, stability)		
• **Hip** (deformity, joint pain, ROM, hip flexors, labrum)		
• **Thigh** (Hamstrings, Quadriceps)		
• **Knee** (MCL, LCL, ACL, PCL, Meniscus)		
• **Lower Leg** (PTSS, Achilles tendon)		
• **Ankle** (talar tilt, anterior drawer)		
• **Foot/Toes** (supination, pronation, pes cavus, pes planus, bunions)		
Evidence of Marfan Syndrome		

Student-Athlete capable of (CHECK ONE):

________Unlimited Athletics at Gavilan College

________Conditional Athletics at Gavilan College – Conditions:____

________Limited Athletics at Gavilan College – Disallowed Sports:______________________________________

________No Athletics at Gavilan College

Physician's Signature Required (MD/DO):____________________________________ Date: ____________________.

Print Physician's Name:__________________________________.

Physician's Phone Number if not on stamp: (_____)______-________.

Doctors Office Stamp Required