



# Odessa College

## Student-Athlete General Information

Sport \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex \_\_\_\_\_

Current address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Current phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Pager \_\_\_\_\_

Email address \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Country (if international) \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Country (if international) \_\_\_\_\_

Student-Athlete Name (Print)

Student-Athlete Signature

Date

Parent/Guardian Signature

Date



# Odessa College

## Student-Athlete Insurance Information

*Please include copies of insurance and prescription cards*

**Student-Athlete Name** \_\_\_\_\_ Sport \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Permanent address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Local address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Father's name** \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's name \_\_\_\_\_

Employer's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Insurance company \_\_\_\_\_

Insurance phone \_\_\_\_\_

Group Policy # \_\_\_\_\_ Certificate # \_\_\_\_\_

Mailing address for claims \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Is your dependent son/daughter covered under the above policy?** Yes  No

**Mother's name** \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's name \_\_\_\_\_

Employer's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Insurance company \_\_\_\_\_

Insurance phone \_\_\_\_\_

Group Policy # \_\_\_\_\_ Certificate # \_\_\_\_\_

Mailing address for claims \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Is your dependent son/daughter covered under the above policy?** Yes  No

\_\_\_\_\_

Parent(s) Signature

Date



# Odessa College

## Pre-Participation Physical Evaluation

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Percent Body Fat (Optional) \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Yes  No  Pupils: Equal  Unequal

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes / Ears / Nose / Throat			
Lymph Nodes			
Heart-auscultation of the heart in the supine position			
Heart-auscultation of the heart in the standing position			
Heart-lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg / Ankle			
Foot			

**Cleared**       **Cleared after completing evaluation/rehabilitation**       **Not cleared**   
 Notes: \_\_\_\_\_

The following information must be completed and signed by either a physician, a physician assistant licensed by a State Board of Physician Assistant Examiners, or a registered nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other healthcare practitioner will not be accepted.

Physician Name \_\_\_\_\_ Date of examination \_\_\_\_\_  
 Full Address \_\_\_\_\_  
 Phone number \_\_\_\_\_ Physician Signature \_\_\_\_\_



# Odessa College

## Pre-Participation Physical History

Student-Athlete Name \_\_\_\_\_ Sport \_\_\_\_\_

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Have you had a medical illness or injury since your last checkup or sports physical?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Have you ever had surgery?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Are you currently taking any prescription or nonprescription/over-the-counter medications or pills or using an inhaler?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Have you ever had a rash or hives develop during or after exercise?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Have you ever passed out during or after exercise?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Have you ever been dizzy during or after exercise?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Have you ever had chest pain during or after exercise?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. Do you get tired more quickly than your friends do during exercise?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. Have you ever been told you have a heart murmur?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 14. Has any family member or relative died of heart problems or of sudden death before age 50?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15. Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 16. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 17. Have you ever had a head injury or concussion?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18. Have you ever been knocked out, become unconscious, or lost your memory?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 19. Have you ever had a seizure?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 20. Do you have frequent or severe headaches  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 21. Have you ever had numbness or tingling in your arms, hands, legs or feet?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 22. Have you ever had a stinger, burn, or pinched nerve?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 23. Have you ever become ill from exercising in the heat?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 24. Do you cough, wheeze, or have trouble breathing during or after activity?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 25. Do you have asthma?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 26. Do you have seasonal allergies that require medical treatment?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 27. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 28. Have you had any problems with your eyes or vision?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 29. Do you wear glasses, contacts, or protective eyewear?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

(Continued on next page)

**For Females ONLY**

Do you have any gender-specific medical conditions the athletics program needs to be aware of? Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

**For ALL Student-Athletes**

*Please check any of the following that apply to you & give dates of any x-rays, MRIs, or other tests performed.*

Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent sore throats	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nervous stomach	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Appendicitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent diarrhea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hemorrhoids	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hernia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney infection/stones	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gout	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bladder infection/stones	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epileptic attacks	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Infectious mono or glandular fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent colds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent skin infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chicken pox	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>

Explain "Yes" answers here: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a sprain, strain or swelling after injury? Yes  No

Have you broken or fractured any bones or dislocated any joints? Yes  No

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Yes  No

If yes, check all that apply below.

- |                               |                                    |                                  |                                 |                                    |                                |
|-------------------------------|------------------------------------|----------------------------------|---------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Chest     | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hand   | <input type="checkbox"/> Thigh     | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Forearm | <input type="checkbox"/> Finger | <input type="checkbox"/> Knee      | <input type="checkbox"/> Foot  |
| <input type="checkbox"/> Back | <input type="checkbox"/> Upper arm | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Hip    | <input type="checkbox"/> Shin/calf |                                |

Explain "Yes" answers here: \_\_\_\_\_  
\_\_\_\_\_

Do you know of, or do you believe there is any health reason why you should not participate in an intercollegiate athletics program at this time? Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

The undersigned, herewith,

- Understands that he or she must refrain from practice or play while ill or injured, whether or not receiving medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participating despite continuing treatment.
- Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him or her at time of said examination.
- Certifies that the answers to the above questions are correct and true.

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date



# Odessa College Medical Policy

1. Odessa College will pay the provider(s) only for medical expenses resulting from athletic injuries that are sustained while participating in official OC practices and games.
  - a. OC's insurance personnel will first file a claim on the student-athlete/parent's personal insurance. All student-athletes must have an insurance policy. If there is a balance after the student-athlete/parent's insurance pays, OC's insurance will be responsible for the remaining balance.
  - b. OC will not be responsible for any conditions, whether athletics or non-athletics related.
  - c. All medical appointments needed as a result of an athletics injury are to be made by the athletics training staff. If this procedure is not followed, the student-athlete/parent may be held responsible for the medical costs incurred. Any treatments performed by a personal or family physician should be coordinated through the athletics training staff.
2. Non-athletic injuries/illnesses are the student athlete's/ parent's financial responsibility
  - a. Although the OC athletics program does not assume financial responsibility for non-athletic injuries/illnesses and prescriptions, we will assist the student-athlete in arranging appointments with the appropriate physicians when at all possible.
  - b. These physicians work on a "payment at the time of service" basis, but will usually assist in filing insurance claim forms for student-athletes in the event of a major expense.
3. Prescriptions for student-athletes are handled in the same manner as described in numbers one and two.
4. The OC athletics program IS NOT RESPONSIBLE for the Pre-Participation Physical Evaluation. It is required as a part of our medical information process and allows for a much smoother pre-participation screening process for our program. This physical should be completed by a family physician prior to arriving at OC.

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Student-Athlete Name (Print)

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Student-Athlete Signature

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Date

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Parent/Guardian Signature

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Date



# Odessa College

## General Authorization and Consent Form for Student-Athletes

I understand that my performance as an athlete and the reputation of my team and the university are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules and regulations set forth by the university, the Athletic Director and the coaches for the sport( s) in which I participate. In addition:

1. I authorize the athletics director and coaching staff to enter my room( s) of school residence or on the road to check: tor cleanliness and/or violations of university and athletics program policies. I agree that articles found in said rooms which may be in violation of said policies or law may be confiscated and will subject me to disciplinary and/or legal action.
2. I authorize Odessa College, through its dually constituted authorities, to test me for alcohol and illegal drugs. The results of said tests will be released to those university officials as designated by the athletics director.
3. This authorization shall constitute a full medical release of all information relative to my physical condition, past, present or future, and authorizes persons possessing said information, including physicians and hospital personnel, to report on, discuss and provide copies of records concerning my physical condition and their opinions regarding same with the athletics director and members of the coaching staff of the university.
4. I authorize the academic advisor designated by the Athletic Director to obtain information regarding my academic status from those who possess same report concerning said information to my parents/guardian/spouse and coaching staff
5. I hereby release Odessa College, its Board of Trustees, its officers, employees, and any physician and medical. personnel performing in accord with this authorization and the university Drug/Alcohol Testing Program for Student-Athletes from any legal responsibility or liability as a result of their compliance with this authorization and said program, including but not limited to, the release of such information and records as authorized by this form.

**This authorization and consent is made pursuant to the Family Education Rights to Privacy Act for release of all the above educational and other records to the parties above named.**

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Student-Athlete Name (Print)

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Student-Athlete Signature

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Date

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Parent/Guardian Signature

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Date



# Odessa College Drug-Testing Consent Form

I have received, read, and been given a chance to ask questions about the Odessa College Intercollegiate Athletics Drug and Alcohol Education and Testing Program (Program). I agree to abide by the provisions of the program. In addition:

1. I hereby consent to have a sample of my urine collected and tested for the presence of drugs or alcohol in accordance with the Odessa College Intercollegiate Athletics Drug and Alcohol Education and Testing Program.
2. I understand that selection for testing will be based on random selection, a prior positive test as outlined in the program, reasonable suspicion of misuse/abuse or other reasonable cause, or prior to WJCAC or NJCAA championship competition.
3. I understand that any urine samples will be sent only to a licensed medical laboratory for actual testing, and that the samples will be coded to ensure confidentiality.
4. I hereby authorize the release of such testing results to the director of athletics, team physician, head coach, head athletics trainer and other university officials as deemed appropriate. I understand that these results will also be made available to me.
5. I understand that I am free to withdraw this consent for drug and alcohol testing. However, I also understand that should I refuse to submit to testing at the time requested, I will not be permitted to participate in intercollegiate athletics competition.
6. I hereby release Odessa College, its trustees, officers, employees and agents from legal responsibility or liability for the release of such information and records as authorized by this form.

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Student-Athlete Name (Print)

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Student-Athlete Signature

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Date

---

Parent/Guardian Signature

---

Date



# Odessa College

## Emergency Contact Information

Student-Athlete Name \_\_\_\_\_

Sport \_\_\_\_\_

### Person(s) whom we should contact in case of an emergency:

#### Emergency Contact #1

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relation to Student-Athlete \_\_\_\_\_

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#### Emergency Contact #2

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relation to Student-Athlete \_\_\_\_\_

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#### Emergency Contact #3

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relation to Student-Athlete \_\_\_\_\_

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# Odessa College

## Athletic Medical Form Packet Checklist

- Completed Student-Athlete General Information Form
- Completed Student-Athlete Insurance Information Form
- Copy of Athlete's Insurance Card (front and back). All athletes must have health insurance. They must provide proof of coverage on a parent's policy or they must purchase coverage through the university.
- Copy of prescription card (if they have prescription coverage)
- Completed Pre-Participation Physical Evaluation (signed by student-athlete)
- Completed Pre-Participation Physical History (this form must be completed by a physician before arriving on campus)
- Medical Policy (signed by Parent/Guardian and Student-Athlete)
- General Authorization and Consent Form (signed by Parent/Guardian and Student-Athlete)
- Drug-Testing Consent Form
- Emergency Contact Information Sheet