Howard College

ATHLETIC TRAINING ROOM (432) 264-5048
1001 Birdwell Lane, Big Spring, TX 79720

Dear Howard College Athlete:

Congratulations! We are excited about your decision to come to Howard College this fall, and we are looking forward to meeting you. We have enclosed a packet of forms, which you need to read carefully, sign and send back to us in the enclosed envelope before your arrival on campus. This packet includes the following forms:

1. **Medical Insurance Information Form**
2. **Authorization for the Release of Medical Information Form**
3. **Medical Liability Release Form**
4. **Injury Policy**
5. **Medical History Questionnaire**
6. **Pre-participation Physical Exam Form (Physician's Report):** Athletes are required to attain a complete physical examination each year prior to any participation in your sport. You will not be allowed to participate in any practice, conditioning, games etc. until this exam is complete. Your coach will be notified when you have been cleared for participation. Please sign and return as soon as possible.
7. **Drug Test Consent Form:** Howard College drug tests throughout the school year by the methods described in Drug Policy and Drug Testing Policy. These policies may be reviewed during office hours in the Athletic Department, or you may view a policy at **www.howardcollege.edu/publications/athletics_manuel**. Please sign consent form and return as soon as possible.
8. **Authorization Statement:** This form insures that information on your academic, team participation, and mental and physical well-being will be shared with the appropriate individuals. Please sign and return as soon as possible.
9. **Athletic Department Policies Offer:** You may request at any time during regular office hours to read any of the listed department policies. Please sign and return as soon as possible.
10. **Insurance and Claim Information:** You and your parents need to read and understand how injury/illnesses are to be handled and how claims are processed. This form is for information only and does not need to be sent back.
11. **Emergency Information Travel Card:** This will be on file in the training room and will be taken to all out of town contests by the athletic trainer in case of emergency. Please sign and return as soon as possible.

If you have any questions, please contact your coach. Your prompt attention will be greatly appreciated. See you in August!

Sincerely,

Britt Smith	John Overton
Athletic Director	Head Athletic Trainer

Howard College

ATHLETIC TRAINING ROOM (432) 264-5048
1001 Birdwell Lane, Big Spring, TX 79720

MEDICAL INSURANCE INFORMATION FORM

Please return the completed form **along with a copy of your health insurance card (front and back) and prescription card** in the envelope provided.

PART I: HEALTH INSURANCE

NAME OF ATHLETE ____
Social Security #

NAME OF INSURED PARTY (subscriber name)______________________________
Social Security #

RELATIONSHIP TO ATHLETE ____________ INSURED PARTY'S DATE OF BIRTH__________

INSURANCE COMPANY NAME ______________________________________

PHONE NUMBER ______________________________________
AREA CODE NUMBER

CLAIMS ADDRESS ______________________________________

____
CITY STATE ZIP

POLICY NUMBER (ID#)______________________________________

GROUP NUMBER___________________ GROUP NAME_________________________

1. Is your insurance company a PPO or HMO? HMO______ PPO ______ NO_______
2. Do you need a referral from your Primary Care Physician to see another doctor? YES____NO___
   Name of Primary Care Physician ______________________ Phone #______________________
3. Does your insurance company require pre-authorization for treatment, MRI, or other scans?
   Yes______ No______
   Pre-certification phone # __________________________
4. Do you have a prescription card? Yes ______ No______

Howard College

ATHLETIC TRAINING ROOM (432) 264-5048
1001 Birdwell Lane, Big Spring, TX 79720

Howard College Athletics
1001 Birdwell Lane
Big Spring, TX 79720
(432) 264-5048 Office

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Part II

The Family Education Right to Privacy Act is a federal law that governs the release of a student's education records, including personally identifiable information (name, address, social security number, etc.) from those records. Medical information is considered part of a student-athlete's educational record. In 1998 this law was amended and parents will be notified by Howard College officials when the student violates Federal, State, Local or college alcohol and/or drug laws or policies.

This authorization permits the athletic trainers, team physicians, and athletics staff (including coaches) of Howard College to disclose information concerning my medical status, medical condition, injuries, prognosis, diagnosis, and related personally identifiable health information to the authorized parties listed below. This information includes injuries or illnesses relevant to past, present or future participation in athletics at Howard College.

The purpose of a disclosure is to inform the authorized parties of the nature, diagnosis, prognosis, or treatment concerning my medical condition and any injuries or illnesses. I understand once the information is disclosed it is subject to re disclosure and is no longer protected.

I understand that Howard College will not receive compensation for its disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information disclosed under this authorization

I understand that I may revoke this authorization at any time by providing written notification to the Athletic Director. I understand revocation will not have any effect on actions the college has taken in reliance on this authorization prior to receiving the revocation. This authorization expires six years from the date it is signed.

______________________________	____________________
Printed Name of Student-Athlete	Sport
______________________________	
Social Security #	
______________________________	____________________
Signature of Student-Athlete	Date
______________________________	____________________
Signature of Parent/Legal Guardian (If Student-Athlete is under 18 years of age)	Date

Howard College

ATHLETIC TRAINING ROOM (432) 264-5048
1001 Birdwell Lane, Big Spring, TX 79720

MEDICAL LIABILITY RELEASE

I, _______________________________________ , fully accept all responsibility and assume all risk for my participation in the athletic program at Howard College.

I acknowledge receiving a letter concerning the policy that the Department of Intercollegiate Athletics adheres to, concerning medical insurance for the student-athlete. I have read and understood the Athletic Department's financial responsibility to a student-athlete who is injured during participation in intercollegiate sports at Howard College.

I hereby release Howard College, its officials, coaches and other employees, or agents from any and all claims or action resulting from any and all accidents, illnesses, or injuries I may sustain while participating in any or all phases of the Howard College Athletic Program. I certify that I am eighteen years of age or older and legally responsible for my actions.

____ ________________

Student-Athlete Signature **Date**

____ ________________

Parent or Guardian Signature **Date**
(Must have if not 18 years old)

A copy of this authorization shall be considered as effective, and as valid as the original.

Howard College

ATHLETIC TRAINING ROOM
1001 Birdwell Lane, Big Spring, TX 79720
(432) 264-5048

INJURY POLICY

The Howard College Intercollegiate Athletic Department follows the policies set by the NJCAA. The athletic department will be responsible for medical services on student-athletes if the student-athlete is injured in practice or a game which was under the coaches' supervision with the coaches or his representative present. The word injury applies only to those ailments that are caused by the participation in practice or a game; for example, the athletic department cannot be responsible for the removal of tonsils or appendix by surgical procedure.

The process for securing medical aid for injury is as follows:

1. During the hours which the training room is open, report injuries in person to the Head Athletic Trainer.
2. At night or during hours when the training room is not open, contact the Head Athletic Trainer.
3. If you are sent to the doctor, you will be required to take a slip signed by the athletic trainer to present to the doctor. After your visit, you are to return the yellow slip to the athletic trainer who sent you to the doctor. If you do not take a slip to the doctor or do not return the yellow slip, you will be responsible for the expense.
4. If the doctor gives you a prescription, you will return that to the trainer and he will see that it is filled. If the athletic trainer has not approved a prescription, you will be responsible for the expense.
5. If for any reason you receive a medical bill, return it immediately to the trainer so that it can be paid.

Student-Athlete Signature ______________________ **Date** ____________

HOWARD COLLEGE

Athletic
Department

MEDICAL HISTORY QUESTIONNAIRE

PLEASE READ THE FOLLOWING CONSENT FORMS CAREFULLY:
(If you are under 18 years of age, your parents must also sign)

The basic content of each is:

I. Medical Consent:	Allows Howard College Athletic Trainers and Physicians to treat any injury you receive while at Howard College.
II. Release of Information:	Allows those listed to release information concerning your injuries to the media.
III. Release of Information:	Allows those listed to release information concerning your injuries to your Parents or Guardians.
IV. Release of Information:	Allows those listed to release any and all information concerning you, including records and others items listed, to professional, agents, scouts, etc.
V. Shared Responsibility For Sport Safety:	Acknowledges that there are certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks.

PART I – MEDICAL CONSENT

I hereby grant permission to the Howard College Team Physicians and/or their consulting physician to render, any treatment or medical or surgical care that they deem reasonably necessary to the health and well being of the student-athlete.

I also hereby authorize the athletic trainers at Howard College who are under the direction and guidance of the Howard College Team Physician: to render any preventive, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to the health and well-being of the student-athlete.

Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

Date	**Student-Athlete Signature**
Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:	**Social Security Number**
	Parent or Guardian Signature

PART II – AUTHORIZATION FOR RELEASE OF INFORMATION

This is to authorize the Howard College Athletic Trainers, Team Physicians, and Athletic Coaches to release medical information: to the Howard College Media Relations Department, and the various media outlets, any information concerning illness or injury relative to my past, or future participation in athletics at Howard College.

Date	**Student-Athlete Signature**
Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:	**Social Security Number**
	Parent or Guardian Signature

PART III – AUTHORIZATION FOR RELEASE OF INFORMATION

This is to authorize the Howard College Athletic Trainers, Team Physicians, and Athletic Coaches to release medical information: to my parents or guardians, any information concerning illness or injury relative to my past, present, or future participation in athletics at Howard College.

Date	**Student-Athlete Signature**
Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:	**Social Security Number**
	Parent or Guardian Signature

PART IV – AUTORIZATION TO RELEASE INFORMATION

I, ______________________________________, hereby authorize and request Howard College, the Board of Trustees, the Howard College Athletic Department and their duly authorized agents, servants or employees (including coaches, athletic trainers, and physicians): to furnish to all professional athletic teams, their scouts, representative agents, athletic trainers, physicians, servants or employees, any and all information concerning or having bearing upon my participation in athletics at Howard College. This authorization shall include, but is not limited to: information within their knowledge, or contained in any records under their supervision or control concerning my physical condition, illnesses, injuries, and any treatment, hospitalization, examination, X-rays, or otherwise, and to make such reports to such persons or organizations concerning myself as they may request; and I hereby fully discharge all parties to whom this authorization extends from any and all privilege in connection with the disclosure of information included in this authorization.

______________________ ______________________________

Date **Student-Athlete Signature**

Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian:

____

Social Security Number

____

Parent or Guardian Signature

PART V – SHARED RESPONSIBILITY FOR SPORTS SAFETY

Participation in sport requires an acceptance of risk of injury. Student-Athletes rightfully assume that those who are responsible for the conduct of the sport have taken reasonable precaution to minimize such risk, and that their peers participating in the sport will not intentionally inflict injury upon them.

There are periodic analyses of injury patterns done to help in modifications, refinements in the rules and safety decisions for the athlete. However, to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with the rule book is as insufficient as to rely on warning labels to produce compliance with safety guideline. "Compliance" means respect on everyone's part for the intent and purpose of a rule or guideline.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating at Howard College.

______________________ ______________________________

Date **Student-Athlete Signature**

____

Social Security Number

____

Parent or Guardian Signature

HOWARD COLLEGE

Athletic Department

FAMILY MEDICAL HISTORY QUESTIONNAIRE

NAME: Last___________________________ First_________________________ Middle____________________

SS # _____-_____-_____ Date of Birth ____/____/____ Age______ Sex_____ Sport_____________________

Home: Address____ Phone # (_____)________________________

City__________________ State____________________ Country_________________ Zip________

Has Any Blood Relative Ever Had:	(Please Circle One)		Who
	YES	NO	
Sudden Death (Before Age 55)	YES	NO	
Blood Diseases (Sickle Cell, Leukemia)	YES	NO	
Diabetes	YES	NO	
Epilepsy	YES	NO	
Gout	YES	NO	
Heart Disease	YES	NO	
Hemophilia	YES	NO	
High Blood Pressure	YES	NO	
Mental Disorders	YES	NO	
Stroke	YES	NO	
Tuberculosis	YES	NO	
Drug and/or Alcohol Dependency	YES	NO	

GENERAL MEDICAL HEALTH HISTORY

Do you CURRENTLY have any of the following SYMPTOMS or PROBLEMS?:

	YES	NO		YES	NO
Frequent Headaches			Abdominal Pain		
Visual Changes			Muscle Cramps		
Ringing in Ears			Frequent Nausea		
Sore Throats			Frequent Vomiting		
Sinus Congestion			Frequent Diarrhea		
Breathing Difficulty			Rectal Bleeding		
Recurring Coughing			Unusual Fatigue		
Chest Pain			Trouble Sleeping		

GENERAL MEDICAL HEALTH HISTORY (Continued)

Have you EVER had the following medical conditions?:

	YES	NO		YES	NO
High Blood Pressure			Skin Disease		
Rheumatic Fever			Diabetes		
Rheumatic Heart Disease			Sickle Cell Anemia/Cancer		
Pericarditis			Anemia		
Any Heart Disease?			Abnormal Bruising		
Tumor, Growth, Cyst, Cancer			Abnormal Bleeding Tendency		
Any ruptured organs?			Blood Disease		
Hepatitis			Blood Clots		
Jaundice			Kidney Disease		
Gout			Kidney Stones		
Pleurisy			Kidney Injury		
Pneumonia			Blood in Urine		
Polio			Frequent Urinary Infections		
Bronchitis			Hearing Defect/Loss		
Frequent Respiratory Infections			Ear Infection		
Tuberculosis			Muscular Disease		
Malaria			Birth Defects		
Mumps			Appendicitis		
Mononucleosis			Stomach Ulcer (Peptic)		
Red Measles			Gastrointestinal Bleeding		
Rubella			Constipation		
Chicken Pox			Hemorrhoids		
Asthma			Hernia		
Exercise Induced Asthma			Arthritis		
Recurrent Sinusitis			Joint Inflammation		
Sinus Infection			Herpes (Oral, i.e. cold sore)		
Nasal Polyps			Herpes (Genital)		
Nose Fracture			Sexually Transmitted Diseases		
Amnesia			Car or Air Sickness		
Meningitis			Nervous Breakdown		
Migraine Headaches			Mental Disorder		
Seizure Disorder			Drug Dependency		
Goiter, Thyroid Disease					

COMMENTS:

GENERAL MEDICAL HEALTH HISTORY (Continued)

INTERNAL

Were you born with a complete and functional set of paired organs? (eyes, ears, kidneys, ovaries/testicles, lungs):
(Check) YES____ or NO____ ; If not, which organs were involved?________________________________
____

Have you ever had surgery to repair or remove any organ? (hernia, tonsils, appendix, spleen, etc.):
(Check) YES____ or NO____
1. If yes, which organ?:___________(Check) Repaired:____ or Removed:____ Date:_________________
Physician:______________________ Address of Physician:_______________________________________
2. If yes, which organ?:___________(Check) Repaired:____ or Removed:____ Date:_________________
Physician:______________________ Address of Physician:_______________________________________

CARDIAC

	YES	NO
Have you ever felt dizzy, light-headed or passed out during or after exercise?		
Have you ever had chest pain while exercising?		
Have you ever had irregular heart beats or heart palpitations?		
Have you ever been told you have a heart murmur?		
Have you ever been seen by a heart specialist (cardiologist)?		
If yes? Who: Date:		
Have you ever had an echocardiogram?		
Have you ever had a stress (heart) exam?		

VISION

	YES	NO	
Have you ever been to an eye doctor?			Date of last visit:_______________
			Physician's name:_______________
Do you wear glasses now?			
If yes, Reading only:			Rx: R___________
Distance only:			L___________
All the time			
Do you wear contact lenses?			
If yes, Soft lenses:			Rx: R___________
Hard lenses:			L___________
Do you have a second pair?:			
Do you wear contact lenses/glasses to participate?			
Have you ever had an eye injury?			Date of incident:_______________
			Explain:_______________
Do you have a color vision problem?			_______________
Have you ever worn a false eye?			

DENTAL – Do you now have or experienced any of the following?:

	YES	NO	COMMENTS
Do you have a bridge or false teeth?			
Have you ever fractured a tooth?			
Have you had a tooth knocked out?			
Do you wear a mouth protector?			
Do you wear orthodontic appliances?			

HEAT – Have you ever experienced any of the following?:

	YES	NO
Trouble with dehydration (Excessive loss of salt and water)		
Heat Stroke		
Heat Cramps (Due to fluid loss because of excessive heat)		
Heat Intolerance		

GENERAL MEDICAL HEALTH HISTORY (Continued)

ALLERGIES - Are you allergic to. . .?:

	YES	NO
Aspirin		
Codeine		
Cortisone		
Sulfa		
Anti-Inflammatories		
Penicillin		
Hay Fever		

	YES	NO
Insect Bites/Stings		
Tetanus Antitoxin or Serums		
Nail Polish or Cosmetics		

Any Foods:

Any other Drug:

Other:

DRUG, FOOD SUPPLEMENTS AND MISCELLANEOUS AGENTS

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

	Never	Rarely	Occasionally	Frequently
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives				
Alcoholic Beverages				
Antihistamines				
Anti-Inflammatories				
Caffeine				
Tobacco				
Creatine Monohydrate				
Other				

MISCELLANEOUS – Have you ever. . .?:

	YES	NO
Worn hearing aids		
Stuttered or stammered		
Coughed up blood		
Bled excessively after injury		
Been advised to have any operations		

	YES	NO
Do you have any pins, staples, or wires in any part of your body		
Had any illnesses other than those already noted		
Have you ever missed a game because of illness		

If yes, to any of the questions above, please explain and tell when it occurred: ______________________________

____

____

____

List all medications that you currently take:______________________________

____

____

____

ORTHOPEDIC HISTORY QUESTIONNAIRE

PLEASE PLACE A CHECK IN EITHER THE "YES" OR "NO" BOX. IF YOU CHECKED "YES," INDICATE THE DATE AND COMMENTS ABOUT THE INJURY. IF YOU HAVE ANY QUESTIONS OR UNCERTAINTIES, PLEASE ASK ANY MEDICAL PERSONNEL FOR ASSISTANCE.

HAVE YOU EVER INJURED OR CONSULTED A DOCTOR ABOUT ANY INJURY TO THE. . . .

HEAD	YES	NO	DATE	COMMENTS
Unconscious				
Dazed/Dizzy				
Knocked Out				
Concussion				
Headaches				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

NECK	YES	NO	DATE	COMMENTS
Sprain/Strain				
Stretches				
Pinches				
Disk Injury				
Dislocations				
Burners/Stingers				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

CHEST WALL	YES	NO	DATE	COMMENTS
Fractured Collar Bone				
Fractured Ribs				
Sterno-Clavicular Joint Separation				
Bruise				
Pains				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)

LOWER BACK	YES	NO	DATE	COMMENTS
Sprain/Strain				
Nerve Pinches				
Disk Injury				
Referred Pain				
Pain Down Leg				
Numbness in Leg				
Weakness in Leg				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

SHOULDERS	YES	NO	DATE	COMMENTS
Sprain/Strain				
A-C Separations				
Dislocations				
Partial Dislocations				
Shoulder Slips Out of Place				
Tendonitis				
Bursitis				
Bruise				
Injections				
Pain w/ Overhead Activities				
Arm Goes “Dead” After Trauma				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

UPPER ARMS/ FOREARMS	YES	NO	DATE	COMMENTS
Strain				
Dislocations				
Casted/Splints				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)

ELBOWS	YES	NO	DATE	COMMENTS
Sprain/Strain				
Bursitis				
Dislocations				
Joint Locking				
Casted				
Tendonitis				
Bruise				
Swelling				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

WRISTS	YES	NO	DATE	COMMENTS
Sprain/Strain				
Tendonitis				
Dislocations				
Casted				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

HANDS/FINGERS	YES	NO	DATE	COMMENTS
Sprain/Strain				
Dislocations				
Casted/Splints				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)

PELVIS/HIPS	YES	NO	DATE	COMMENTS
Sprain/Strain				
Groin Pulls				
Torn Muscles				
Dislocations				
Casted				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

THIGHS	YES	NO	DATE	COMMENTS
Sprain/Strain				
Quad Pulls				
Hamstring Pulls				
Torn Muscles				
Calcium Deposits				
Bruise				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

KNEES	YES	NO	DATE	COMMENTS
Strained				
Sprain Ligament				
Torn Ligament				
Torn Cartilage				
Knee Cap Injury				
Knee Cap Dislocation				
Osgood Schlatter's				
Bursitis				
Swelling				
Locking				
Giving Away				
Sudden Weakness, Shifting				
Wear Braces				
Casted				
Arthritis				
Chandromalacia				
Grinding				
Tendonitis				
Jumper's Knee				

(cont.)

ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)

KNEES (cont.)	YES	NO	DATE	COMMENTS
Bruise				
Injections				
Pains				
Pain w/ Stairs				
Pain w/ Squats				
Fractures				
Arthrograms				
X-rays, CT, MRI				
Hospitalized				
Arthroscopes				
Surgery				
Missed Practice				
Missed Games				
Other				

LOWER LEGS	YES	NO	DATE	COMMENTS
Sprain/Strain				
Shin Splints				
Torn Muscles				
Bruise				
Injections				
Pains				
Painful – Tight Calf w/ Activity				
Achilles Tendon Pain				
Stress Fracture				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ANKLES	YES	NO	DATE	COMMENTS
Sprain/Strain				
Dislocations				
Casted/Splinted				
Bruise				
Instability				
Giving Out				
Weakness				
Injections				
Pains				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

ORTHOPEDIC HISTORY QUESTIONNAIRE (Continued)

FEET/TOES	YES	NO	DATE	COMMENTS
Sprains				
Turf Toe				
Dislocations				
Casted/Splinted				
Bruise				
Injections				
Fractures				
X-rays, CT, MRI				
Hospitalized				
Surgery				
Missed Practice				
Missed Games				
Other				

OTHER MEDICAL CONCERNS

	YES	NO
Have you had or do you now have any other medical problems or injuries not listed on this form?		
Do you have any medical or health problems that you are currently receiving medical treatment for?		
Is there any reason that you are not able to participate in athletics?		
Are there any additional health problems you would prefer to discuss privately with our team physician?		

If any of the first three questions above were answered with "YES", please explain below:

____
____
____
____
____
____

The undersigned, herewith,

A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.
B. Certifies that the answers to these questions are correct and true.
C. Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
D. Fully realizes the Howard College Athletic Department cannot be held responsible for any previous medical condition(s) that he/she might have.

______________________________________ ______________________
Student-Athlete Signature **Date**

Upon completion of this History Form, it is to be reviewed and signed by the Howard College Athletic Trainer.

______________________________________ ______________________
Athletic Trainer Signature **Date**

Pre-participation Physical Evaluation

Students Name__________________________________ Sex_______ Age______ Date of Birth___________

Height________ Weight________ Pulse_______ BP ____/____ (_____/_____,_____/_____)

Vision R 20/____ L 20/____ Corrected Y N Pupils: Equal_____ Unequal_____

As a minimum requirement this Physical Examination Form must be completed prior to participation.

	Normal	Abnormal Findings	Initials*
Medical			
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			
Lunges			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

* Station-based examination only

Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:____

☐ Not cleared for:______________________________ Reason:____

Recommendations:____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners.

Name (print or type)____ Date of Examination:_____________

Address:____

Phone Number:____

Signature:____

Must be completed before a student participates in any practice or game(both in-season and out of season)

Howard College

ATHLETIC TRAINING ROOM (432) 264-5048
1001 Birdwell Lane, Big Spring, TX 79720

AUTHORIZATION STATEMENT

I do hereby understand and give the head coach or assistant coaches of my respective sport, the athletic director, or the head athletic trainer of Howard College, Big Spring, TX, permission to communicate with my parent(s) and/or legal guardian(s), former high school or college coaches, summer league coaches, prospective employers, educational or professional individuals that could further my educational or professional advancements concerning information about grades, compliance or non-compliance of Howard College, Howard College Athletic Department, or Howard College team policies, my mental or physical health, or progress in the area of my team at Howard College.

Further, the above persons may communicate with my instructors, coaches, professional staff, and administrators of Howard College concerning the above mentioned items.

ATHLETIC DEPARTMENT POLICIES OFFER

I have been informed that I may request to review the following policies for the athletic department at any time during regular office hours. I understand that these policies are available to me in the athletic training department or the athletic director's office and that any questions about these policies should be directed to either the athletic director or head athletic trainer.

1. Howard College Junior College District Intercollegiate Athletics Substance Abuse Program.
2. Howard College Athletic Injury/Accident Policy.
3. Howard College Athletic Medical Examination Policy.

______________________	______________________
Print Name	**Signature**
______________________	______________________
Social Security Number	**Date**

Howard College

ATHLETIC TRAINING ROOM (432) 264-5048
1001 Birdwell Lane, Big Spring, TX 79720

INSURANCE AND CLAIM INFORMATION

Howard College and our athletic department are committed to providing the best medical care possible through a full-time head athletic trainer and student trainer staff and an on-campus health clinic. Our entire purpose is to do the very best we can to ensure both athlete and parent(s) that medical coverage for injury/illness is a top priority and the ultimate goal is the complete restoration of health and well-being of the athlete.

PAYMENT OF CLAIMS: Through each department, many of the injury and illness issued can be addressed. In addition, the athletic department provides a secondary insurance policy that works with athletes injured in their sport and who posses medical coverage under a primary insurance plan. Claims are considered by Howard College's secondary policy after the primary insurance plan carried by the athlete has paid. The athlete is responsible for turning in the Explanation of Benefits received from the primary insurance plan to the head athletic trainer for secondary payment. If you do not carry a primary plan, our policy becomes a limited primary coverage. There could be unpaid medical charges under the limited primary plan. **The student athlete is responsible for these medical charges**. However, the head athletic trainer will review all unpaid balances and could make payment of any outstanding balance.
Note: Non-athletic illnesses/injuries are not covered by the secondary plan.)

SUGGESTIONS:

1. If you have a primary plan (on parent's insurance or your own) and it is a preferred plan for the area you live in, you may contact your local agent and see if your plan can be moved to Big spring under a physician in our community. Examples are PPO's, HMO's, and other type plans. If you are unable to use a physician in this area, you might consider traveling back to your hometown for treatment. This would ensure the primary care plan to be in effect. The secondary plan is not affected by location. This is the most cost effective claim payment. The head athletic trainer will be able to answer any questions you may have on our local physicians.
2. If your primary care plan will not allow you to move to a new area, your insurance agent could have information on an extended medical coverage plan for college students away from home that could be an attachment to the primary plan. These type plans are specifically for college students, usually not expensive, and are effective for the school year.
3. If you do not have a primary care plan, I would encourage you to consider purchasing a plan that would cover you while attending Howard College. The cost of purchasing one of these plans is far less than having extensive medical charges.

Drug Test Consent Form

I ______________________________ hereby consent to have samples of my urine collected and tested to determine if certain drugs are present. I understand that urinalysis testing is required by the Athletic Department of Howard College and is part of the approved policies governing the institution. The results of said test will be kept confidential and can only be viewed by the director of athletics, Head coach of my sport, Assistant Coach so designated by the head coach, the Head athletic trainer, Dean of students and any administrator so designated by the college.

If the results of said test show a positive use of illegal drugs, steroids or alcohol the athlete will have an opportunity to discuss the matter with the director of athletics, Head coach of my sport, Head athletic Trainer and the Dean of Students, and to present evidence of any rebuttal or mitigating circumstances which he or she feels important. Following this discussion, a decision concerning my participation in athletics at HCJCD will be made at that time by the Director of athletics, Head coach of my sport, Dean of Students, and the Head athletic trainer. The decision being one of the following:

1. A probationary period with immediate loss of scholarship for a designated period of time.

2. Suspension from the team with immediate loss of scholarship for the remainder of the school year.

3. Sanctions issued by the Dean of Students

Furthermore, if the results of said test show a positive use of illegal drugs, steroids or alcohol or other controlled substance, that athlete or their specimen can be retested to assure the athlete continues to show negative use of illegal drugs, steroids, or alcohol has occurred, and the cost of these test will possibly be charged to the student.

You are free to refuse to consent to drug testing under this program. However, upon declining participation in the testing program, which is designed to protect your health and reputation, you will not be eligible for a scholarship or to participate in any intercollegiate sport offered by Howard College. If you refuse to test for drugs as provided in this policy, after initially consenting, you shall be considered to have made a decision not to participate and will forfeit your scholarship immediately. **I also acknowledge that I have been provided with a copy of Howard College's drug testing policy.** I understand that under the Family Education Right to Privacy Act, That Howard College officials will release alcohol and drug violations and results of drug test to parents or legal guardians.

Howard College, its Board of Trustees, Its officers, employees and agents are hereby released from any legal responsibility or liability as a result of their compliance herewith.

____
Print Name (Student Athlete)

____ __________________________
Signature (Student Athlete) Date

HOWARD COUNTY JUNIOR COLLEGE EMERGENCY INFORMATION CARD

Athlete's Name ____ D.O.B____/____/____Age________

FIRST MI LAST

Athlete's Address____

City_______________________State______________________________Zip____________________

Athlete's Social Security Number________/_________/_________

Sport___________________________

Do you have Hospital (Medical) Insurance? Yes__________ No_______

If yes, covered by: (Check One): Parent's Policy_________ Your Policy___________

If Parent's Policy: Father or Mothers' Name____

Social Security Number _______________________________________

Date of Birth ____

Name of Insurance Company ____

Company Address ____

Insurance Certification # ____

Group # ____

Type ____

In case of Serious Accident or illness, permission is given for Emergency Treatment, Routine Immunization, X-Rays, Skin Tests for Diagnosis and Hospitalization.

____

SIGNATURE OF PARENT / GUARDIAN / STUDENT ATHLETE, IF 18 YEARS OF AGE OR OLDER

IN CASE OF EMERGENCY, CONTACT:

Name: ____

Address: ____

Relationship: ____

Phone: Home____

Business ____

Other ____

Family History: List serious illnesses of close relatives, example: Diabetes, Heart Disease, Tuberculosis, etc.: ____

____

____

IMPORTANT INFORMATION FOR INCOMING STUDENTS

During the last legislative session, Texas House Bill 4189 was passed and signed into law by Governor Rick Perry. HB 4189 requires that any incoming new student who lives on campus must either receive a vaccination against bacterial meningitis or meet certain criteria declining such a vaccination before they can live on campus.

WHO DOES THIS APPLY TO?

Any student who enrolls at Howard College after January 1, 2010, who lives on campus.

10 DAY WAITING PERIOD

As contained within the provisions of HB 4189, a student who receives the Bacterial Meningitis vaccination may not move into the residence hall until at least 10 days after receiving the vaccination.

WHAT IF I CANNOT RECEIVE THE VACCINATION PRIOR TO THE BEGINNING OF THE SEMESTER?

According to HB 4189, no incoming student may live on campus unless they have had the vaccination at least 10 days prior to living on campus. **(August 10).**

WHAT IF I DO NOT WANT TO GET THE VACCINATION?

Exceptions to this requirement must be documented on a conscientious exemption form from the Texas Department of Health Services. Information concerning an exemption form request can be obtained here under the heading of “Exclusions from Immunization Requirements.”

WHERE DO I SEND MY PROOF OF VACCINATION?

Howard College STUDENT HOUSING
1001 Birdwell Lane
Big Spring, TX 79720
PLEASE INCLUDE YOUR DATE OF BIRTH ON ALL DOCUMENTATION!

CAN I BRING MY VACCINATION FORM ON MOVE IN DAY?

NO, all forms related to your Bacterial Meningitis vaccination status must be received in the Student Housing Department at least 3 working days before move-in day, so that records can be updated. For more information about Bacterial Meningitis, please contact your local or regional Texas Department of Health office.

REMEMBER THESE DATES:

August 10 – Last day to receive vaccination to be eligible to move into residence hall on move in day, August 21.

August 17 – Last day for proof of vaccination to be received by Student Housing Department to be eligible to move into residence hall on move in day, August 21. **STUDENTS MAY NOT BRING PROOF OF VACCINATION ON MOVE-IN DAY.**

BACTERIAL MENINGITIS VACCINATION FORM

Print Name ________________________________ College ID# __________________________

HB 4189 Bacterial Meningitis Vaccination

In compliance with HB 4189, a first-time student attending an institution of higher education, including a transfer student, who has applied for on-campus and has been approved to reside in an on-campus student housing facility (provided space is available), must provide written documentation of having received the bacterial meningitis vaccination.

Evidence of the student having received the vaccination from an appropriate health practitioner must be received by the Student Housing Office. The student will not be assigned a space in housing and may lose their position on the waitlist if this document is not on file. This information shall be maintained in accordance with Family Education Rights and Privacy Act Regulations.

I have been vaccinated and am providing evidence by one of the following

_____ An official record generated from a state or local health authority (*submit copy*)

_____ An official record generated from school officials, including a record from another state (*submit copy*)

_____ Received the vaccination from a registered health care provider (*fill out section below*)

Date of vaccination _____/_____/_____

Signature of Health Care Provider _____________________________ Date _____/_____/_____

OR

Office stamp of the physician or his/her designee, or public health personnel:

Date _____/_____/_____

I am exempt from the vaccine and am providing evidence by one of the following

A student, or a parent or guardian of a student, is not required to submit evidence of receiving the vaccination against bacterial meningitis if, under one of the following circumstances, the student, or a parent or guardian of a student submits one of the following to the institution.

_____ An affidavit or a certificate signed by a physician who is duly registered and licensed to practice medicine in the United States, in which it is stated that, in the physician's opinion, the vaccination required would be injurious to the health and well-being of the student.

_____ an affidavit signed by the student stating that the student declines the vaccination for bacterial meningitis for reasons of conscience, including a religious belief. **A conscientious exemption form from the Texas Department of State Health Services must be read.** https://webds.dshs.state.tx.us/immco/affidavit.shtm

The exception noted in Section 21.614(B) does not apply during a disaster or public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency declared by an appropriate official or authority from the Texas Department of State Health Services and is in effect for the location of the institution the student attends.