INSTRUCTIONS FOR NEW STUDENT-ATHLETE MEDICAL PACKET

1. USE BLACK OR BLUE **PEN**, PENCIL IS NOT ACCEPTED.
2. THOROUGHLY COMPLETE **BOTH** EMERGENCY CARDS WITH IDENTICAL INFORMATION.
3. READ, FILL OUT AND SIGN FORMS 1-4. FORM 4 IS TWO-SIDED.
4. FORMS 5 &6 ARE TO BE FILLED OUT BY THE MEDICAL EXAMINER. ONLY FILL IN YOUR NAME AND DATE OF BIRTH ON THESE FORMS.
5. **NO CHIROPRACTIC EXAMS!** PHYSICAL EXAMS MUST BE DONE BY A MEDICAL DOCTOR.
6. WHEN COMPLETE, PLEASE RETURN TO THE ATHLETIC TRAINING ROOM (BUILDING 2000) OR DIVISION OFFICE (BUILDING 1200).

ANY QUESTIONS PLEASE CALL 530-741-6837

EMERGENCY CARD

ATHLETE'S NAME:________________________ BIRTH DATE:__________ SS#________________

ADDRESS:____________________________ CITY:________________ STATE:_____ ZIP:______

PHONE:________________ PARENT/GUARDIAN NAME:_____________________________

PARENT/GUARDIAN ADDRESS:____

PARENT/GUARDIAN HOME PHONE:__________________ WORK PHONE:__________________

INSURANCE COMPANY:____

INSURANCE CO. PHONE #________________ POLICY/ID#________________ GROUP#__________

ALLERGIES:______________ 2ND EMERGENCY CONTACT:____________________________

ADDITIONAL NOTES:____

EMERGENCY CARD

ATHLETE'S NAME:________________________ BIRTH DATE:__________ SS#________________

ADDRESS:____________________________ CITY:________________ STATE:_____ ZIP:______

PHONE:________________ PARENT/GUARDIAN NAME:_____________________________

PARENT/GUARDIAN ADDRESS:____

PARENT/GUARDIAN HOME PHONE:__________________ WORK PHONE:__________________

INSURANCE COMPANY:____

INSURANCE CO. PHONE #________________ POLICY/ID#________________ GROUP#__________

ALLERGIES:______________ 2ND EMERGENCY CONTACT:____________________________

ADDITIONAL NOTES:____

www.yccd.edu

Athletic Department
Phone: 530-741-6779
Fax: 530-634-7705

Yuba Community College District
2088 North Beale Rd.
Marysville, CA 95901

Yuba College
2088 North Beale Rd.
Marysville, CA 95901

Woodland Community College
2300 E. Gibson Rd.
Woodland, CA 95776

Yuba College - Clear Lake Campus
15880 Dam Road Extension
Clearlake, CA 95422

TO:	**Parents/Guardians of Student Athletes attending Yuba College**
FROM:	**Erick Burns, Athletic Director**
SUBJECT:	**Athletic Medical Insurance**

We are excited about having your son/daughter participate as a student-athlete at Yuba College. We hope that he/she finds their total experience at Yuba College rewarding.

Yuba College has Certified Athletic Trainers on site to see to your daughter's/son's medical needs. We will do everything possible to keep them free from athletic injuries while practicing and competing at Yuba. However, total elimination of injuries is virtually impossible.

With this in mind, Yuba College has acquired an excess medical insurance program for your son's/daughter's protection in the event of accident-based injuries sustained while participating in supervised practice or scheduled competition. This will guarantee that all athletes will have some protection in the event that they are not currently insured in the parent's/guardian medical insurance program. This policy is with Cypress Risk Management, is underwritten by Pan American Life Insurance, claims will be administered by NAHGA Claims Services. A brochure is available upon request for your further knowledge and review. Again, please note that this policy is for helping to provide coverage for accident-based injuries sustained during Yuba College supervised practices or scheduled games.

Again, please note this program is EXCESS over any other valid insurance program in effect for the athlete at the time of the accidental injury. The coverage WILL NOT pay 100% in most cases, therefore, the athlete and her/his parent or guardian will be responsible for any unpaid balances not covered by the insurance program.

If you have any questions concerning this insurance program: for claim questions call NAHGA Claims Services Toll Free (800) 952-4320, for the local agent Monique Palmieri-Wilson at 310-420-6064, or contact the Yuba College Certified Athletic Training Staff at 530-741-6837.

I/We have read and understand the above information regarding student-athlete medical coverage here at Yuba Community College.

Student-Athlete Signature:_______________________________ **Date:**__________

Parent/Guardian Signature:_______________________________ **Date:**__________

(if under 18 years old)

Yuba Community College District

Sports Medicine Participation Agreement

Awareness of Risk

It is important for all student athletes to know that there is always a risk of bodily injury when participating in competitive intercollegiate athletics. It is possible that these injuries may be catastrophic, meaning permanent, serious injury, including partial paralysis, total paralysis or even death.

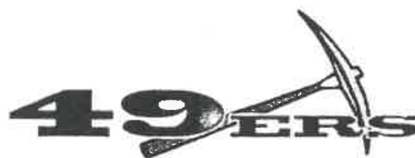
"Because of the dangers of participation in sport, I recognize the importance of listening to and following all of the coach's and certified athletic trainer's instructions and warnings regarding playing strategies, training methods, rules of sport, injury rehabilitation and other team rules. I also recognize the importance of reading and adhering to all written instruction and written warnings regarding playing techniques, training methods, rules of sport and other team rules. I understand that all instructions and warnings, verbal and written are incorporated by reference to this agreement and I hereby promise to obey all such instructions and warnings."

I have read the above statement and fully understand its implications. I acknowledge the risk inherent in sport and choose to participate with this knowledge.

Athlete's Signature:______________________________ **Print Name:**______________________________

Parent/Guardian Signature (if under 18 yr. old):______________________________ **Date:**_______________

Sport:______________________________



Yuba College
Student-Athlete Concussion Statement

By initialing each statement, I am aware and understand the following information:

___I understand that it is my responsibility to report all injuries and illnesses to the athletic trainer, coach, and/or team physician.

___ A concussion is a brain injury, which I am responsible for reporting to my athletic trainer, coach, and/or team physician.

___ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

___ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury(See examples of signs & symptoms).

___ If I suspect a teammate has a concussion, I am responsible for reporting the injury to the athletic trainer, coach, and/or team physician.

___ I will not return to play in practice or game I have if I received a blow to the head or body that results in concussion related symptoms.

___ Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.

___ In rare cases, repeat concussions can cause permanent brain damage and even death.

Signature of Student-Athlete	Print Name	Date
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Examples of signs & symptoms:

-Increasingly severe headache or a headache lasting for more than 48 hours-
-Excessive dizziness-Excessive drowsiness-Excessive vomiting-
-Obvious change in behavior or personality(irritability, confusion etc.)-
-Changes in ability to see- Unsteady walking- Difficulty concentrating-
-Significant difference in pupil size- Convulsions-
-Discharge of blood or clear fluid from nose, ears, or mouth-
-Paralysis or marked weakness in arms, legs, or facial muscles-

Medical History

Name:____________________________Student ID#/or SS#_____________________Date:___________

Birth Date:_________________ Sport:_______________________Position:________________________

Check whether you have had any of the following injuries or conditions.
If YES, provide approximate date(s) and details below.

YES	NO	INJURIES/CONDITIONS
		HEAD INJURIES
		BROKEN NOSE
		NECK INJURIES INVOLVING NERVES, BONES OR SPINAL CORD
		SHOULDER DISLOCATION, SEPARATION OR OTHER
		ELBOW INJURY
		WRIST, HAND OR FINGER INJURY
		BACK INJURY, OR LOW BACK PAIN THAT REQUIRED MEDICAL TREATMENT
		HIP INJURY
		KNEE INJURY
		"SHIN SPLINTS"
		ANKLE INJURY
		FOOT INJURY
		FRACTURED BONES OTHER THAN LISTED ABOVE (STRESS FRACTURES)
		OTHER SIGNIFICANT MUSCULOSKELETAL INJURY
		DO YOU HAVE A DENTAL PLATE OR BROKEN,CHIPPED OR LOOSE TOOTH?

List dates and details of above injuries:____

____

Check whether you have had any of the following conditions.
If YES, provide approximate date(s) and details of treatment below.

YES	NO	CONDITION	YES	NO	CONDITION
		ANEMIA			KIDNEY DISEASE
		BLOOD IN URINE			LIVER DISEASE
		DEPRESSION			MIGRAINE HEADACHES
		DIABETES			MONONUCLEOSIS
		EPILEPSY OR SEIZURES			EATING DISORDER
		FREQUENT DIARRHEA			ULCERS
		HEART DISEASE			UNUSUAL BLEEDING
		HEART MURMUR			UNUSUAL BRUISING
		HEART PALPITATIONS			ASTHMA
		HEAT ILLNESS			ALLERGY TO MEDICATION
		HERNIA			OTHER ALLERGIES
		HEPATITIS A,B OR C			HIGH BLOOD PRESSURE
		SUDDEN DEATH IN FAMILY MEMBER UNDER AGE OF 40			MISSING ORGANS(EYE, TESTICLE, KIDNEY)

List dates and details of above conditions:____

____

Medical History

Check whether you have experienced any of the following conditions.
If YES, please provide approximate date(s) and/or details.

YES	NO	CONDITION	DETAILS		
		FAINTING			
		CONCUSSION			
		HOSPITALIZATION			
		TAKING MEDICATION	DRUG	DOSAGE	REASON

***DO YOU OR ANYONE IN YOUR FAMILY CARRY SICKLE CELL TRAIT: YES_______ NO________**

The information on this form is true and complete to the best of my knowledge. I have been honest and forthcoming in the disclosure of all my medical issues and prior injuries that may be pertinent to my sport participation clearance. I hereby state that I am in excellent health, and fit to participate in intercollegiate athletics.

Signature:____Date:________________

Signature of Parent/Guardian(if under 18):________________________________Date:________________

PHYSICAL EXAM

NAME____________________ DATE____________________

BIRTH DATE____________________ STUDENT ID #____________________

MUSCULOSKELETAL ASSESSMENT

AREA	NORMAL	ABNORMAL	COMMENTS
NECK			
SPINE			
LOW BACK/PELVIS			
SHOULDERS			
ROTATOR CUFF			
ELBOWS			
WRISTS			
HANDS/FINGERS			
HIPS			
HAMSTRINGS			
KNEES			
ANKLES			
FEET			

CLEARED TO PARTICIPATE IN SPORT ○		**PENDING CONSULTATION** ○
CLINICIAN'S NAME		CREDENTIAL
CLINICIAN'S SIGNATURE		ADDITIONAL NOTES
PHONE	DATE	

YUBA COMMUNITY COLLEGE SPORTS MEDICINE

PHYSICAL EXAM

NAME________________________________ DATE____________________________

BIRTH DATE___________________________ STUDENT ID #____________________

BLOOD PRESSURE	PULSE	HEIGHT	WEIGHT

VISION: R 20/____ **L** 20/____ **CORRECTED:** Y N **PUPILS:** EQUAL_____ UNEQUAL_____

GENERAL ASSESSMENT

AREA	NORMAL	ABNORMAL	COMMENTS
HEAD			
EYES			
ENT			
LUNGS			
CARDIOVASCULAR			
ABDOMEN			
GU			
SKIN			
NEUROLOGICAL			

CLEARED TO PARTICIPATE IN SPORT ⬭		**PENDING CONSULTATION** ⬭
CLINICIAN'S NAME		CREDENTIAL
CLINICIAN'S SIGNATURE		ADDITIONAL NOTES
PHONE	DATE	

REVIEWED BY:

DATE: