ATHLETIC PACKET

1. Fill out all forms in the packet except the Physical Examination Form. In the event that you are having your physical done in Health Services: DO NOT complete the athletic history form within the packet, you will complete an athletic history online when you check in.

2. Healthcare providers must fill out and sign the Physical Examination Form.

3. Please read the following carefully:

   - You must submit your completed athletic packet to a Nurse in the Health Services (Room A 364).The nurse needs to see you and talk to you in person before issuing the physical verification form that is required for participation on our athletic teams. We encourage you to make an appointment to turn in your athletic packet, since wait times are unpredictable. You can call 847-925-6268 to set up an appointment.

   - Physicals are valid for one calendar year and must cover the entire sport season.

   - After you receive the Athletic Verification form from Health Services, give both copies of the form to the Athletic Program Assistant (Room M219) Monday-Friday 8:00 – 4:30. Do not give the form to anyone else. You must be cleared prior to the first practice or tryout.

   - Please complete and submit the entire packet; do not attempt to turn in the physical exam by itself. Health Services cannot clear you unless all pages in the packet are attached and complete.

   - If you do not have a personal physician, you may schedule a physical exam with Health Services, at a cost of $25-35 (HPS accepts checks or credit cards only and you must pay at the time of service). Call 847-925-6268 to schedule your appointment; they do not accept walk-ins for this service. These appointments are limited.

   - All students using Harper's Health Services must have their HarperCard, Student I.D.

   - The Health Services is closed on Saturday and Sunday. No services of any kind are available on those days. Please take this into consideration when planning your physical exam and/or turning your packet in to Health Services for athletic clearance.

Harper College

ATHLETIC HEALTH HISTORY

Health Services
A Building, Room 364
Phone: 847-925-6268

Name (Last, First, Middle) _____ Date of Birth ____/____/____

Sex _____ Age _____ Sport(s) _____

Medicines Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking: _____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below:

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging insects Other: _____

Explain "Yes" answers below. Circle questions you don't know the answer to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion? Last concussion_____ (date) Seen by a health care provider yes/no		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of food?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here: _____

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

Signature of Athlete: _____ Date: _____

PHYSICAL EXAMINATION FORM– Must be completed by a licensed health care provider

PATIENT NAME _____ DOB _____

REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Yes ☐ No		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)**		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic***		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
**Consider GU exam if in private setting. Having third party present is recommended.
***Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
☐ Not Cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____ Reason _____

Recommendations _____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Health Care Provider _____ Date _____
Address _____ Phone _____

Signature of Health Care Provider _____
05/23/2014

INSURANCE INFORMATION

Parents/Guardians/Student: Complete all information, sign on reverse and return form to:

Harper College
Health Services, A364
1200 West Algonquin Road
Palatine, IL 60067-7398

Name of Athlete:_____ Sport:_____

Social Security Number:_____ Birth Date:_____

Local Address:_____ Local Phone:_____

City/State/Zip:_____

Home Address: _____ Home Phone: _____

City/State/Zip: _____

Complete all blanks on this form. Failure to complete all blanks will result in claim processing delays.
If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Father/Guardian:_____ Mother/Guardian:_____

Address:_____ Address:_____

_____ _____

Phone: _____ Phone: _____

Employed by:_____ Employed by:_____

Address:_____ Address:_____

_____ _____

Phone: _____ Phone: _____

Medical Insurance Company or Plan: Medical Insurance Company or Plan:

_____ _____

Address:_____ Address:_____

_____ _____

Phone: _____ Phone: _____

Group/Policy Number:_____ Group/Policy Number:_____

ID Number: _____ ID Number: _____

Is the above athlete covered under this plan? ☐ Yes ☐ No Is the above athlete covered under this plan? ☐ Yes ☐ No

Is this plan an HMO ☐ Yes ☐ No or a PPO? ☐ Yes ☐ No Is this plan an HMO ☐ Yes ☐ No or a PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ No Is a second opinion required before surgery? ☐ Yes ☐ No

Does the athlete have any medical insurance coverage under his/her name exclusively? Yes ☐ No ☐

If yes, complete the following:

Medical Insurance Company or Plan: _____

Address: _____ Policy Number: _____

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

This insurance covers acute injuries ONLY during the specific intercollegiate sport season as determined by the NJCAA. Off season injuries or injuries incurred outside of team practice or competition are NOT included. Illnesses and chronic injuries are also not included.

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent that we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

We authorize that Harper College or its insurance agent pay the medical vendor direct for any bills incurred from accidents that are covered under the coverage purchased by the College.

This Authorization is valid from the date signed for the duration of the claim.

Name of Student (please print)

Name of Parent/Guardian (please print)

Relationship to Student

Signature of Student

Signature of Parent/Guardian

Date

Date

RETURN TO M219

Harper College Athletics Emergency Contact Information

Athlete Information:

Sport: _____ Student I.D. # _____

Name, Last _____ First _____ Middle Initial: _____

Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Local Address: _____ City: _____ State: _____ Zip: _____

M F Age: _____ D.O.B. ____/____/____

Physician: _____ Phone: _____

Allergies: _____

Medications: _____

In Case of Emergency:

Contact Name: _____ Phone: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Name: _____ Phone: _____ Relationship: _____

Primary Insurance Information:

Insured Name (Parent/Guardian): _____

Insurance Company: _____

Insurance Co. Phone: _____

Policy/ Group #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

HMO PPO

Release of Information: I hereby authorize the hospital and participating physicians to release any appropriate insurance entity or agency the information needed to process the claims in reference to this hospital/physician's visit(s).

Consent to Treat: I hereby give my permission for a licensed physician and or hospital employee to administer the necessary medical treatment and/or procedures to the named student athlete.

Student Athlete Signature: _____ Date: ____/____/____