Edmonds College Athletics
20000 68th Ave West, Lynnwood WA 98036
athletics@edmonds.edu | P: 425-640-1415 | Fax: 425-640-1102

STUDENT-ATHLETE

Email:_____

Student Name _____ Gender _____
(Last) (First) (Middle Initial)

Date of Birth _____ Age _____ SID _____
Month/Day/Year

Local Address _____ Phone (_____)_____
(Number & Street) (City) (Zip)

Home Address _____ Phone (_____)_____
(Number & Street) (City) (Zip)

PARENT/GUARDIAN

Parent(s) Name _____
(Last) (First) (Middle Initial)

Home Address _____ Phone (_____)_____
(Number & Street) (City) (Zip)

INSURANCE INFORMATION

Are you covered by group or individual health and/or accident insurance? Yes ❑ No ❑
If yes, please provide the following information:

Insurance Co. _____ Policy/Group #_____

Subscriber's Name _____ Subscriber ID#_____

EMERGENCY CONTACTS

Name _____ Phone (_____)_____ Relationship _____

Name _____ Phone (_____)_____ Relationship _____

FAMILY PHYSICIAN

Name _____ Phone (_____)_____

SPORTS PROGRAM(S)

Please check ALL appropriate boxes for the sports in which you will be participating at this college:

❑ Baseball	❑ M Basketball	❑ M Golf	❑ M Track	❑ M Rodeo	❑ M Swim
❑ Softball	❑ W Basketball	❑ W Golf	❑ W Track	❑ W Rodeo	❑ W Swim
❑ Volleyball	❑ M Cross Country	❑ M Soccer	❑ M Tennis	❑ M Wrestling	❑ Other
	❑ W Cross Country	❑ W Soccer	❑ W Tennis	❑ W Wrestling	_____

MEDICAL CONDITIONS (e.g., medical conditions, allergies, or current medications)

_____

PLEASE CAREFULLY AND COMPLETELY READ THE FOLLOWING INFORMATION

Completion of this medical history and examination form is mandatory for participation in the sports programs of this college. Please make sure that all statements regarding your personal information and medical history is complete and accurate.

NWAC Regulations state: "After July 1st and prior to the first practice for participation in intercollegiate athletics, a student shall undergo a thorough medical examination and be approved for intercollegiate athletic competition by a medical authority licensed to perform a physical examination by the laws applicable in the state where the exam is conducted. Those licensed and approved to perform physical examination by the laws applicable in the state where the exam is conducted." Those licensed to perform physical examinations in the State of Washington include M.D., Doctor of Osteopathy (D.O.), Certified Registered Nurse (C.R.N.), Naturopath (N.D.) and Physician's Assistant (P.A.). The physical examination shall be valid for twenty-four (24) consecutive months to the date unless otherwise limited by the physician indicating the physical is only good for less than twenty-four (24) consecutive months.

This form is to be completed and signed by the student or, if the student is under the age of 18, by the student's parent or guardian. Any Information withheld or falsified may affect the student's status on the athletic team and/or the student's scholarship funding. The college reserves the right, with the student's authorization, to request past medical records, charts and diagnoses regarding injuries, medical history or physical condition, and may request additional medical examinations or tests if indicated.

INFORMATION ABOUT YOUR LAST PHYSICAL EXAMINATION:

Date _____ Doctor's name _____ City, State _____

Please list any abnormalities found on any past physical examinations _____

_____

IMMUNIZATION RECORD

Measles*	❑ Yes	❑ No	Date of last shot _____
Mumps*	❑ Yes	❑ No	Date of last shot _____
Rubella*	❑ Yes	❑ No	Date of last shot _____
Polio	❑ Yes	❑ No	Date of last dose _____
Tetanus (Td)	❑ Yes	❑ No	Date of last shot _____
COVID-19	❑ Yes	❑ No	Date of last dose _____

*Note: These are commonly noted on immunization records as "MMR" and often given as one shot. A second dose of measles vaccine is recommended for college entrance.

FAMILY MEDICAL HISTORY

Please check YES or NO in appropriate box.

1.	❑ Yes	❑ No	Osteoporosis	5.	❑ Yes	❑ No	Hemophilia
2.	❑ Yes	❑ No	High blood pressure	6.	❑ Yes	❑ No	Diabetes
3.	❑ Yes	❑ No	Neuromuscular disease	7.	❑ Yes	❑ No	Anemia
4.	❑ Yes	❑ No	Sudden death from heart disease or stroke	8.	❑ Yes	❑ No	Cancer

If living, please check box to signify family member's general health. If deceased, please state age and cause of death, if known.

						Age at Death	Cause of Death
Father	❑ Excellent	❑ Good	❑ Fair	❑ Poor	❑ Deceased		
Mother	❑ Excellent	❑ Good	❑ Fair	❑ Poor	❑ Deceased		
Brother #1	❑ Excellent	❑ Good	❑ Fair	❑ Poor	❑ Deceased		
Brother #2	❑ Excellent	❑ Good	❑ Fair	❑ Poor	❑ Deceased		
Sister #1	❑ Excellent	❑ Good	❑ Fair	❑ Poor	❑ Deceased		
Sister #2	❑ Excellent	❑ Good	❑ Fair	❑ Poor	❑ Deceased		

MEDICAL CONDITIONS & ILLNESSES

Have you ever had or do you now have any of the following medical conditions, illnesses or diseases? Please check YES or NO for <u>EACH</u> item.

	YES	NO			YES	NO			YES	NO	
9.	❑	❑	Polio	26.	❑	❑	Recurrent sinusitis	43.	❑	❑	Hernia or rupture
10.	❑	❑	Diphtheria	27.	❑	❑	Hearing loss/ear disease	44.	❑	❑	Ulcers
11.	❑	❑	Rheumatic fever	28.	❑	❑	Rheumatic heart disease	45.	❑	❑	Testicular masses
12.	❑	❑	Hepatitis	29.	❑	❑	Heart murmur/problems	46.	❑	❑	Hemorrhoids
13.	❑	❑	Tuberculosis	30.	❑	❑	Pericarditis	47.	❑	❑	Bleeding disease
14.	❑	❑	Collapsed lung	31.	❑	❑	High blood pressure	48.	❑	❑	Anemia
15.	❑	❑	Pneumonia	32.	❑	❑	Elevated cholesterol	49.	❑	❑	Phlebitis
16.	❑	❑	Pleurisy	33.	❑	❑	Arthritis/joint problems	50.	❑	❑	Asthma/hay fever
17.	❑	❑	Diabetes	34.	❑	❑	Bone infection	51.	❑	❑	Skin disease/rash
18.	❑	❑	Allergies	35.	❑	❑	Chondromalacia	52.	❑	❑	Measles
19.	❑	❑	Tumors/Cancer	36.	❑	❑	Seizures/Epilepsy	53.	❑	❑	Mumps
20.	❑	❑	Muscular disease	37.	❑	❑	Migraine headaches	54.	❑	❑	Mononucleosis
21.	❑	❑	Eye disease	38.	❑	❑	Neurological disorder	55.	❑	❑	Malaria
22.	❑	❑	Color blindness	39.	❑	❑	Goiter/thyroid disease	56.	❑	❑	Car or air sickness
23.	❑	❑	Near sightedness	40.	❑	❑	Enlarged organs (spleen)	57.	❑	❑	Nervous breakdown
24.	❑	❑	Far sightedness	41.	❑	❑	Kidney or bladder disease	58.	❑	❑	Mental disorder
25.	❑	❑	Nasal polyps	42.	❑	❑	Gastrointestinal bleeding	59.	❑	❑	Eating disorder

INJURIES & SYMPTOMS

Do currently have or have you ever had any of the following symptoms, problems or injuries?
Please check YES or NO for EACH item.

	YES	NO			YES	NO			YES	NO	
60.	❑	❑	Frequent headache	71.	❑	❑	Neck pain or injury	82.	❑	❑	Muscle weakness
61.	❑	❑	Head injury	72.	❑	❑	Back pain or injury	83.	❑	❑	Muscle cramps
62.	❑	❑	Visual changes	73.	❑	❑	Knee pain or injury	84.	❑	❑	Muscle wasting
63.	❑	❑	Eye pain or injury	74.	❑	❑	Ankle pain or injury	85.	❑	❑	Frequent nausea
64.	❑	❑	Ringing in ears	75.	❑	❑	Shoulder dislocation/sep.	86.	❑	❑	Frequent vomiting
65.	❑	❑	Sore throats	76.	❑	❑	Other joint sprain/disloc.	87.	❑	❑	Frequent diarrhea
66.	❑	❑	Nasal fracture	77.	❑	❑	Joint pain, at rest	88.	❑	❑	Abdominal problems
67.	❑	❑	Sinus congestion	78.	❑	❑	Joint pain, with exercise	89.	❑	❑	Internal injuries
68.	❑	❑	Breathing difficulty	79.	❑	❑	Joint weakness	90.	❑	❑	Rectal bleeding
69.	❑	❑	Recurrent coughing	80.	❑	❑	Pinched nerve	91.	❑	❑	Unusual fatigue
70.	❑	❑	Chest pain	81.	❑	❑	Heat exhaustion/stoke	92.	❑	❑	Trouble sleeping

GENERAL QUESTIONS

Please answer ALL of the following questions by checking either YES or NO for EACH item.

	YES	NO	
93.	❑	❑	Do you now have or have you ever had any chronic or recurrent illnesses?
94.	❑	❑	Have you ever had any illnesses lasting more than one week?
95.	❑	❑	If no to #93 or #94, do you now have or have you ever had any illnesses requiring treatment and care of a doctor?
96.	❑	❑	Do you wear eyeglasses or contact lenses?
97.	❑	❑	Do you currently wear eyeglasses or contact lenses while participating in sports?
98.	❑	❑	Do you use any dental appliances such as braces, bridges or plates?
99.	❑	❑	Any body parts or organs missing (appendix, eye, kidney, testicles)?
100.	❑	❑	Are you now or have you ever been under the treatment of a medical doctor for any injuries?
101.	❑	❑	Have you ever fainted, passed out, been dizzy, knocked out, unconscious or had a concussion?
102.	❑	❑	Have you ever had a cast, splint, cane or crutches?
103.	❑	❑	Have you ever had an X-ray of any bone or joint?
104.	❑	❑	Do you have to stop while running twice around a quarter-mile track?
105.	❑	❑	Do you have any trouble breathing, while at rest, after running one mile?
106.	❑	❑	Do you get any chest pain with exercise?
107.	❑	❑	Have you ever had any injuries or illnesses that caused you to miss a game or practice?
108.	❑	❑	Are there any reasons why you should not participate in sports?
109.	❑	❑	Have any of your close relatives, under the age of 50, died of heart problems or unexplained causes?
110.	❑	❑	Are you or any member of your family allergic to ANY medications (aspirin, penicillin, etc.)?
111.	❑	❑	Are you now taking or have you taken any medications, medicines, drugs or vitamins on a regular basis?
112.	❑	❑	Do you have any medical conditions that require special attention or treatment that the coach or athletic trainer should be aware of in the event of any injury or illness?

*If you have answered "**Yes**" to any numbered item (1-112), please explain the situation or circumstances, including names of treating physicians and dates in the space provided. Identify each response by the number of the item in the left margin.*

Item No.	Physician, City, State	Approx. Date	Explanation, including any surgeries you have had

Student Name _____
(Last) (First) (Middle Initial)

Please list all previous fractures, concussions or other head injuries:

Item No.	Physician, City, State	Approx. Date	Injury

Please list all hospitalizations:

Item No.	Physician, City, State	Approx. Date	Reason for hospitalization, length of stay

Describe your current pattern of physical exercise

Activity	Frequency	Duration	Intensity

Describe the sickest you have ever been _____

_____

Describe any weight changes over the last six months_____

List *all* medications -- prescription and/or over the counter -- drugs or vitamins that you currently take (including aspirin, birth control pills, etc.) _____

_____

Describe any allergies -- from bites, drugs, foods, pollen, etc. -- you may have, including causes and reactions _____

_____

At what age did you have your first menstrual period? _____ How many have you had during the last 12 months? _____

Date of last period _____ Describe any menstrual irregularity or discomfort _____

AGREEMENT OF UNDERSTANDING

I, the undersigned, certify that the above medical history is correct and true to the best of my knowledge, and that this student has no physical defects except as stated. This medical information is given with my permission and the medical examination is taken voluntarily. I further understand that any intentional omission of answers either verbally or in writing may result in disqualification from the community college sports program.

I authorize the release of this medical information, including the medical examination and the results of any medical tests, to the college for their use, evaluation and record keeping for this student-athlete's participation in the sports program of the college. I further authorize the release of this medical information, the medical examination and the results of any medical tests when deemed necessary by the college athletic coach, athletic trainer or other authorized college official; and I grant permission to any hospital, physician, surgeon, or other duly authorized medical personnel to release any other medical records, charts or diagnoses when deemed necessary for the treatment and care of this student-athlete in the event of injury or illness.

I further authorize and request the college's designated medical personnel to administer basic life support, advanced life support, and/or to obtain emergency medical care in the event of injury or illness at any specific emergency care facility so designated by the college physician or representative while participating in the sports program.

By my signature I verify that I have read, understand and agree to the above-stated conditions.

Student _____ Date _____

Parent/Guardian (If student is under 18 years of age)_____

Student Name _____
(Last) (First) (Mid. Initial)

PHYSICAL EXAMINATION FOR SPORTS PARTICIPATION

To be completed by Licensed Medical Provider

To the Medical Provider: Please obtain and review the student's health history, pages one through four of this form, before conducting the examination. The intent of this exam is to focus on conditions of the athlete that may endanger his/her health, aggravate pre-existing conditions or increase the risk of death from participation in competitive college sports. If your findings or observations during this exam for sports participation indicate a need for a more comprehensive medical examination, you have the option of conducting a more comprehensive exam or advising the athletic director of the college in writing of the need for same. We appreciate your assistance and cooperation in maintaining the health of our student-athletes.

Student Name _____
(Last) (First) (Middle Initial)

Date of Birth _____ Male ❑ Female ❑ Height _____ Weight _____
Month/Day/Year

Blood pressure at rest and sitting: Left arm _____/_____ mmHG Right arm _____/_____ mmHG

Resting pulse rate: Apical _____ Radial _____

Visual acuity: Left 20/_____ Right 20/_____ Please check appropriate box: ❑ With correction ❑ Without correction

Please check appropriate box to indicate if Normal or Abnormal, and provide comments if abnormal.

SYSTEM		N	AB	COMMENTS
HEAD	Hair, scalp, masses, injuries			
EYES	Proptosis, conjunctivae, sclera, EOM, pupillary size, reaction to light, peripheral vision, fundi, gross tension to palpation			
EARS	Gross hearing to speech, drums, discharges			
NOSE	Septum, mucosa, sinuses			
THROAT/MOUTH	Teeth, tongue, tonsils, infections, lesions			
NECK	Thyroid, vessels, range of motion, adenopathy, masses, voice abnormalities			
THORAX/LUNGS	Shape, expansion, deformities, rhonchi, wheezes, rales			
HEART	PMI, sounds, thrills, murmurs, gallops, PVCs			
LYMPHATICS	Cervical, axillary			
ABDOMEN	Organ enlargement (liver, spleen, etc.), masses, tenderness, hernias, scars			
GENITALIA	Scrotum, testicles, lesions, discharge, hernias			
RECTAL (Optional)	Hemorrhoids, fissures, prostate, masses			
UPPER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
LOWER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
BACK	Flexion, extension, scoliosis, kyphosis, excessive lordosis, injuries			
NEUROLOGICAL	Cranial nerves, reflexes, motor, gait, balance, sensory			
SKIN	Texture, striae, rash, acne			
MENTAL STATUS	Affect, hostility, agitation, depression, anxiety			
COVID-19 History	History of prior infection	☐ No	☐ Yes	
Do you recommend further COVID-19 or follow up testing after moderate or severe infection? (Cardiology consult or Respiratory Consult)		☐ No	☐ Yes	
Is this individual at high risk for complications if no prior history of infection?		☐ No	☐ Yes	
If yes, were they counseled about their risks of participation in a high-risk activity?		☐ No	☐ Yes	

LABORATORY TESTS (Optional or as indicated by examination)

Urinalysis: Sugar _____ Albumin _____ Ketones _____ Other _____

Hematology: Hematocrit _____

Summary of abnormal lab work _____

If medical history indicates the need for any vaccinations or booster shots, please administer during the physical examination.

Orthopedic Diagnoses _____

_____

General Medical Diagnoses _____

_____

_____

_____

Additional findings or comments on health history/significant injuries or illnesses _____

_____

DISPOSITION **(Please check one)**

- ❑ Unrestricted activity in all sports
- ❑ No participation until _____ or until _____
  (Date) (Conditions to be met)
- ❑ May participate, but with following limitations _____
- ❑ May not participate at all for following reasons _____

Medical Provider's signature _____ Date of Exam _____

MEDICAL PROVIDER IDENTIFICATION (Please print. Stamp or label okay)

Name _____ Phone (_____) _____

Address _____ City _____ Zip _____

Mail completed form to: (COLLEGE)

NOTE: The original of this report shall be confidentially filed and maintained in the athletic department. The information shall be readily available to health care providers in event of an emergency when intercollegiate sports are conducted, both at home and away from the college.

Student Name _____
(Last) (First) (Mid. Initial