Community Colleges of Spokane

RETURNING STUDENT-ATHLETES AND PARENTS

PHYSICAL EDUCATION, ATHLETICS, RECREATION & WELLNESS ■ SPOKANE SASQUATCH ■ HOME OF THE BIGFOOT

Spokane Community College ■ MS 2050
1810 N Greene Street ■ Spokane, WA 99217-5399
509-533-7230 Office ▪ 509-533-8609 Fax ▪ www.scc.spokane.edu

Spokane Falls Community College ▪ MS 3070
3410 W Ft. Wright Drive ▪ Spokane, WA 99224-5288
509-533-3630 Office ▪ 509-533-4102 Fax ▪ www.spokanefalls.edu

The following information is extremely important for athletic preparation and eligibility at Community Colleges of Spokane (CCS). The primary concern of the Athletic Training Staff and team physicians is to provide medical care for student-athletes at CCS. Please read these instructions, complete the appropriate forms, and mail all documents needed to the address below. If you have questions, please contact the HEAD COACH for your sport.

In the required packet, you will find the following forms and requests for associated documents:

1. NWAACC Athletic Questionnaire/Recruiting Disclaimer
This form contains all required NWAACC and CCS required eligibility information. This form must be fully completed, signed and dated.

2. Health History
RETURNING STUDENT-ATHLETES: You are only required to have a full physical exam your first year. Each subsequent year you will be screened by the Athletic Training Staff for changes in your medical status. If needed, you will be referred to a physician for further examination and clearance to participate. If you are currently experiencing a medical problem or have had any major illnesses or significant injury since your last health screening you must provide a written release authorizing your participation in varsity collegiate athletics from your treating licensed health care provider. If you were treated by a Community Colleges of Spokane Athletic Training Staff member and/or team physicians, we will provide this release for you.

3. Insurance Information
Community Colleges of Spokane provides secondary insurance coverage for all student athletes which is in effect during officially scheduled and supervised participation in varsity athletics. Summit America medical insurance administers this excess athletic policy which is designed to pay the balance of covered expenses up to the maximum of the policy after the bills have been processed through the primary insurance. In other words, the Summit America policy is intended to pay any deductibles or co-pays the primary insurance does not pay. Any student athlete who sustains an injury that occurred during supervised participation (when a coach is present) is covered under this secondary policy, up to the policy limits and under its restrictions. The primary insurance will be billed first and student-athletes and/or their parents/guardians if under age 18 are responsible for providing the remaining statement balance to the insurance coordinator for processing payment. Information on the Summit America policy is available upon request of the Athletic Department Administrative Assistant or Athletic Trainer.

In order to provide the proof of primary insurance you must attach a COPY of your insurance card(s) front and back to the insurance form submitted to Community Colleges of Spokane.

4. Student-Athlete Authorization for Release of Protected Health Information
The Athletic Training Staff may refer student-athletes to medical specialists based on a particular issue or injury. In this circumstance, an authorization is necessary for the Athletic Training Staff to provide protected health information to the medical specialist. The Student Consent for Release of Protected Health Information form provides this authorization and is valid for 380 days from the date of your signature.

5. FERPA Consent Form
This form provides consent for college officials to share educational records orally or in writing in order to ensure maintenance of athletic eligibility. This form must be signed and dated to authorize such disclosures.

ALL FORMS MUST BE SUBMITTED TO

Spokane Falls Community College
Attn: Nancy Zacher, MS 3070
3410 W. Fort George Wright Dr.
Spokane, WA 99224-5288

Spokane Community College
Attn: Wendy Irish, MS 2050
1810 N. Greene St.
Spokane, WA 99217-5399

PRIOR TO THE FIRST PRACTICE OF THE YEAR!

Northwest Athletic Association of Community Colleges

ATHLETIC QUESTIONNAIRE

This form MUST be completed and returned to your coach or the college Athletic Office before participating in ANY athletic activity is permitted. All information **MUST BE COMPLETED. FRONT AND BACK. PLEASE PRINT CLEARLY.**

COLLEGE ATTENDING ☐ SCC ☐ SFCC ☐ BOTH	SPORT(S)	SCHOOL YEAR
FULL NAME		☐ MALE ☐ FEMALE
STUDENT ID #		BIRTHDATE
LOCAL ADDRESS		
CITY, STATE, ZIP		
PERMANENT ADDRESS (if different from above)		
CITY, STATE, ZIP		
CELL PHONE	EMAIL	
HIGH SCHOOL	CITY, STATE	GRADUATION DATE

If you did not attend college immediately following high school, identify activities you were involved in during that time period:

DATES	ACTIVITIES

If you have attended other collegiate institutions (including community college) since high school (this includes any previous years at CCS), complete the following:

DATES ATTENDED (MONTH & YEAR)	COLLEGE	CITY/STATE

If a transfer student, number of hours transferred:	Quarter Hours	Semester Hours

Are official transcripts from all previous colleges on file with the admissions office at SCC or SFCC? ☐ YES ☐ NO

ATHLETIC PARTICIPATION

Have you participated in an intercollegiate CONTEST/EVENT since high school? ☐ YES ☐ NO

Have you participated in an intercollegiate PRACTICE since high school? ☐ YES ☐ NO

If YES, list any participation at all colleges attended, including the present college (i.e., CCS):

DATES	PARTICIPATION

Are you currently participating on another team? ☐ YES ☐ NO	If YES, name the team
When was the last time you participated?	Have you notified the team you are leaving? ☐ YES ☐ NO

LETTER OF INTENT

Have you ever signed a Letter of Intent? ☐ YES☐ NO	If YES, for what sport?	
College	City/State	Year:

AMATEURISM

Have you participated on or tried out for a professional team? ☐ YES ☐ NO

Have you ever played with, received payment from, or signed a contract to play with a professional team? ☐ YES ☐ NO

If YES, list sport, organization, and date signed:

SCHOLARSHIPS AND FINANCIAL STATUS	
Have you been awarded an athletic tuition grant-in-aid at this college for this academic year?	☐ YES ☐ NO
Have you received any other (non-athletic) scholarship and/or aid from this college for this academic year?	☐ YES ☐ NO

ALL ACADEMIC TEAM AND ACADEMIC LEADERSHIP AWARD	
College Major:	Educational Goal:
List sport(s) and year(s) participated in high school:	
List athletic and academic honors and awards received in high school:	
List athletic and academic honors and awards received in college:	

ATTENDANCE VERIFICATION			
Are you attending CCS because of the athletic program?			☐ YES ☐ NO
Since your decision to attend, have any friends/relatives also chosen to attend?			☐ YES ☐ NO
If YES, please list their names:	1. _____	4. _____	
	2. _____	5. _____	
	3.	6.	
List your estimated monthly expenses for	Food $	Lodging $	If you live with parent(s) and do not pay, list $0.00.

NWAACC RECRUITING DISCLAIMER
In accordance with the NWAACC Code Book (Article VI, Section 2), athletic recruiting is only allowed in the states of **Oregon, Washington, Montana, Alaska, Hawaii, California, Idaho, Nevada and the province of British Columbia**. Student-athletes whose home residence is outside the aforementioned contiguous states must submit an NWAACC Athletic Questionnaire and Recruiting Disclaimer to the conference office.

To the best of my knowledge, the information I have provided is accurate and complete. I understand that falsification of my academic or athletic participation records will result in immediate suspension of athletic eligibility in any sport at any NWAACC member college.

I give my permission for the Athletic Department to use my student Identification number for eligibility purposes, including use on forms and transcripts, as required when sent to other schools and to the NWAACC office.

STUDENT-ATHLETE'S SIGNATURE _____ DATE _____

NWAACC, PLS 033
Clark College
1933 Fort Vancouver Way
Vancouver, WA 98663

Community Colleges of Spokane

MEDICAL HISTORY UPDATE FORM

PHYSICAL EDUCATION, ATHLETICS, RECREATION & WELLNESS ■ SPOKANE SASQUATCH ■ HOME OF THE BIGFOOT

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This form MUST be filled out and returned to your coach or the college Athletic Office before participation in ANY athletic activity is permitted.
All information **MUST BE COMPLETED**. **PLEASE PRINT CLEARLY**.

TO BE COMPLETED BY SECOND-YEAR OR RETURNING ATHLETES ONLY

FULL NAME (PRINT) _____
LAST FIRST MI

ATTENDING ☐ SCC ☐ SFCC ☐ BOTH SID # _____
###-###-###

SCHOOL YEAR _____ E-MAIL _____

☐ MALE ☐ FEMALE BIRTHDATE _____ AGE _____
MONTH/DAY/YEAR

SPORT(S) _____ ☐ FRESHMAN ☐ SOPHOMORE

LOCAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

PERMANENT ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

THIS INFORMATION WILL BE KEPT CONFIDENTIAL

A. MEDICAL ILLNESS: IN THE PAST YEAR HAVE YOU HAD ANY OTHE THE FOLLOWING?

	Use this column to briefly explain YES answers		
1. Chest pain while exercising		☐ YES	☐ NO
2. Fainted or nearly fainted while exercising		☐ YES	☐ NO
3. Unexplained shortness of breath or fatigue with exercise		☐ YES	☐ NO
4. Suffer from heat illness		☐ YES	☐ NO
5. Been knocked out or experienced a concussion. If **YES**, were you seen by a medical professional?		☐ YES	☐ NO
6. Diagnosis of mononucleosis, pneumonia or other infectious virus		☐ YES	☐ NO
7. Other illnesses, please list:			

FULL NAME (PRINT) _____ SID# _____
LAST FIRST MI ###-##-####

B. GENERAL MEDICAL INFORMATION:

	Use this column to briefly explain YES answers		
1. Do you have or have you ever been treated for diabetes? If **YES**, please list the age at which your diabetes began as well as any and all medications you take for this condition		☐ YES	☐ NO
2. Have you ever had anemia?		☐ YES	☐ NO
3. Do you have sickle cell trait/anemia?		☐ YES	☐ NO
4. Do you have or have you ever had hypoglycemia (low blood sugar)?		☐ YES	☐ NO
5. Do you have a vision defect in either one or both eyes? If **YES**, please specify.		☐ YES	☐ NO
6. Do you wear glasses? ☐ YES ☐ NO	If YES, do you wear them during athletic activity?	☐ YES	☐ NO
7. Do you wear contact lenses? ☐ YES ☐ NO	If YES, do you wear them during athletic activity?	☐ YES	☐ NO
8. Do you wear any dental appliances? ☐ YES ☐ NO	If YES, do you wear them during athletic activity?	☐ YES	☐ NO
9. Do you have a hearing defect? If **YES**, please specify and list any hearing aids worn:		☐ YES	☐ NO
10. Have you had either a gain or loss of ten pounds or more in the past 12 months? Specify:		☐ YES	☐ NO
11. Do you currently take any medications or drugs? If **YES**, what medications or drugs are you taking, dosage information and for what reason:		☐ YES	☐ NO
12. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EAI)? If **YES**, what medication(s)		☐ YES	☐ NO

C. ALLERGIES: Are you allergic to any of the following items?

Aspirin	☐ YES	☐ NO	Penicillin	☐ YES	☐ NO	Acetaminophen	☐ YES	☐ NO	Bee Stings	☐ YES ☐ NO
Codeine	☐ YES	☐ NO	Erythromycin	☐ YES	☐ NO	Novocain or other anesthetics	☐ YES	☐ NO	Iodine	☐ YES ☐ NO
Sulfa Drugs	☐ YES	☐ NO	Ibuprofen	☐ YES	☐ NO	Tetanus antitoxin or serums	☐ YES	☐ NO	Latex	☐ YES ☐ NO
Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If **YES**, please list those allergies here:										☐ YES ☐ NO

D. GYNECOLOGICAL HISTORY: ***ONLY FEMALES ANSWER THIS SECTION***

IN THE PAST 12 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING?

			Years				Years				Years
Absence of Menstruation	☐ YES	☐ NO		Menstrual Cramps	☐ YES	☐ NO		Scanty Flow	☐ YES	☐ NO	
Painful Menstruation	☐ YES	☐ NO		Irregular Periods	☐ YES	☐ NO		Excessive Flow	☐ YES	☐ NO	
Are currently taking Birth Control Pills? ☐ YES ☐ NO				If **YES**, what type are you taking?							

FULL NAME (PRINT) _____ SID# _____
LAST FIRST MI ###-##-####

E. EATING DISORDERS:

	Use this column to briefly explain YES answers		
1. Diagnosis of anorexia? If **YES**, when and where?		☐ YES	☐ NO
2. Diagnosis of bulimia? If **YES**, when and where?		☐ YES	☐ NO
3. A problem with food bingeing?		☐ YES	☐ NO
4. Do you sometimes or often induce vomiting after eating?		☐ YES	☐ NO
5. Taken laxatives to lose weight?		☐ YES	☐ NO

F. INJURIES: IN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING?

	Use this column to briefly explain YES answers		
1. Fracture, sprain, strain that has limited your athletic participation?		☐ YES	☐ NO
2. Chronic injury (ex, Tendonitis) that has limited your athletic participation?		☐ YES	☐ NO
3. Visited a health care provider due to a condition that limited your athletic participation?		☐ YES	☐ NO
4. Participated in physical therapy?		☐ YES	☐ NO
5. Been treated by a chiropractor, massage therapist, or acupuncturist?		☐ YES	☐ NO

G. OTHER:

If you have any additional conditions, problems, or comments that have not been addressed in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

FULL NAME (PRINT) _____ SID# _____
LAST FIRST MI ###-##-####

Certification of Accuracy:

By signing below, I certify that all statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur while participating in athletics at Community Colleges of Spokane. I further understand that any intentional omission of answers either verbally or in writing may result in disqualification from the community college sports program.

Authorization to Release Medical Information:

I authorize the release of this medical information 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 when deemed necessary by the college athletic coach, Certified Athletic Trainer or other authorized college official for the purposes of determining my fitness to participate in athletics and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur while participating in athletics at Community Colleges of Spokane.

I authorize any hospital, physician, surgeon, or other duly licensed health care provider to release any medical records, charts or diagnoses related to the treatment and care of this student athlete to Community Colleges of Spokane in the event of any injury or illness which relates to student athlete's eligibility or ability to participate in athletics or any injury or illness which the student athlete may incur while participating in athletics, including training, conditioning, practices, games, and athletic related events. This authorization expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance to this authorization.

Consent to Medical Care:

I 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 Certified Athletic Trainer 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-ATHLETE SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (IF UNDER 18) _____ DATE _____

Community Colleges of Spokane

ATHLETE'S INSURANCE INFORMATION FORM

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All information **MUST BE COMPLETED**. **PLEASE PRINT CLEARLY**.

FULL NAME (PRINT) _____
LAST FIRST MI

SSN # _____ SID # _____
###-##-#### ###-##-####

SCHOOL YEAR _____ E-MAIL _____

☐ MALE ☐ FEMALE BIRTHDATE _____ AGE _____
MONTH/DAY/YEAR

SPORT(S) _____ ☐ FRESHMAN ☐ SOPHOMORE

LOCAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____

PARENT/GUARDIAN'S INFORMATION

PARENT/GUARDIAN'S NAME _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER NAME _____ EMPLOYER PHONE _____

E-MAIL _____

DO YOU HAVE INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION

ATTACH A COPY OF YOUR INSURANCE CARD FRONT AND BACK
This is REQUIRED prior to participation even if you have provided it in previous years.

PRIMARY INSURANCE

INSURANCE COMPANY NAME _____ PHONE _____

CLAIMS PAYING OFFICE _____

CITY _____ STATE _____ ZIP _____

POLICY NUMBER _____ GROUP NUMBER _____

SUBSCRIBER'S NAME _____ RELATIONSHIP _____

The school athletic insurance policy is excess coverage to any other payable insurance plan. Any cost for medical expenses incurred as a result of accidental injury while participating in the school athletic program will be reduced by the amount collectable from any other insurance plan. If no existing primary insurance is in effect, payments will be made according to the schedule of benefits of the athletic accident policy. Primary insurance includes personal insurance and coverage under parental insurance. If, for any reason, the student's primary insurance does not cover your charges in full or denies your claim, **YOU ARE RESPONSIBLE FOR THE BALANCE.**

I hereby authorize any hospital, trust fund, employer, insurance company, health care provider, or other person who has attended me or any dependent to disclose any and all information with respect to any illness or injury, medical history, consultation, prescriptions, treatment, and provide copies of all hospital or medical records when requested to do so by the Athletic Insurance Company.

This authorization expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance to this authorization.

STUDENT-ATHLETE SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (IF UNDER 18) _____ DATE _____

Community Colleges of Spokane

STUDENT-ATHLETE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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FULL NAME (PRINT) _____ SID# _____
LAST FIRST MI ###-##-####

I hereby authorize **Community Colleges of Spokane** and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in intercollegiate athletics to the **Athletic Director, Associate/Assistant Athletic Directors, Athletic Training Staff and related health care providers (MD specialists, therapists, etc.), Coaches, Sports Information Director, and local media** for the purposes of:

- **Decision making about and plan for my care and/or treatment**
- **Referral, consultation and coordination of with other health care providers for my care and treatment**
- **Determination of my eligibility for health insurance benefits or coverage**
- **Releasing information to the media when a condition or injury affects my ability to participate**
- **Performance of office or administrative functions that support the athletic training department's effort to provide me with effective health care**
- **Facilitation of any other reason permitted by law**
- **Promotion of Community Colleges of Spokane athletics**

I am making this authorization/consent voluntarily to release my health information otherwise protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA), Chapter 70.02 RCW, or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). I understand that my signing of this authorization is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the authorization requested for this disclosure. I also understand that I am not required to sign this authorization in order to be eligible for participation in NCAA or conference athletics.

This authorization expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization.

STUDENT-ATHLETE SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (IF UNDER 18) _____ DATE _____

FERPA CONSENT FORM

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I understand that in order to remain eligible to participate in intercollegiate athletics my academic progress will be monitored by my coaches, counselors and my parents and/or guardians.

I also understand that the potential to be recruited to continue athletic competition at another institution will involve the sharing of information with recruiters, coaches and other college officials outside of this institution.

To these ends, I give my written consent for school officials, including college faculty, administration, staff, and student workers at the Community Colleges of Spokane to share my educational records, in oral or written form, with the above listed parties.

FULL NAME (PRINT) _____ SID# _____

STUDENT-ATHLETE SIGNATURE _____ DATE _____

SPORT(S) _____