Rancho Santiago Community College District

SANTA ANA COLLEGE ATHLETICS

Dear Athlete:

Enclosed you will find medical history, assumption of risk, and pre-participation athletic health screening forms which **MUST** be thoroughly completed by you and returned to the Certified Athletic Trainers prior to the time of your pre-participation health screening.

If these forms are not properly and accurately completed, it could result in the loss of your eligibility to compete. Please do not leave any questions blank.

The following forms are included in your packet:

- Health Screening Packet (signed by a Licensed Medical Doctor/ Physician's Assistant)
- Insurance Verification Packet

Please provide a photocopy of the front and back of your current Medical Insurance Card

If this season of competition is the first since having undergone surgery, we will require a written release from the surgeon.

If you have any questions, please contact the Certified Athletic Trainers.

Thank you for your cooperation.

Gary T. Kinney, M.A., ATC
Certified Athletic Trainer
(714) 564-6941

Nora E. Schug, M.S., ATC
Certified Athletic Trainer
(714) 564-6940

Rancho Santiago Community College District

WARNING, AGREEMENT TO OBEY INSTRUCTIONS, RELEASE, ASSUMPTION OF RISK AND AGREEMENT TO HOLD HARMLESS

☐ SANTA ANA COLLEGE ☐ SANTIAGO CANYON COLLEGE

SPORT: (check all that apply)

Men				Women			
☐	Baseball	☐	Soccer	☐	Softball	☐	Soccer
☐	Football	☐	Swimming/Diving	☐	Volleyball	☐	Swimming/Diving
☐	Basketball	☐	Track	☐	Basketball	☐	Track
☐	Cross Country	☐	Water Polo	☐	Cross Country	☐	Water Polo
☐	Golf	☐	Wrestling	☐	Golf		

I, _____, (Student ID#) _____wish to participate in Intercollegiate Athletics at the Rancho Santiago Community College District, which I understand includes various activities such as practice, weight training, competition, travel, and treatment of injuries ("RSCCD Athletic Activities"). I represent and warrant that I am in good health and physical condition, and I agree that I will not undertake any activity that is not within my physical capabilities.

I hereby understand and acknowledge that as a part of any RSCCD Athletic Activities, there are known and unanticipated risks that could result in physical or mental illness to me. These risks include, but are not limited to: 1.) cuts, bruises, sprains, breaks, trauma, and/or disease; 2.)paralysis that includes loss or impairment of movement, strength, feeling, or use of a body part of function, which could last my entire lifetime, 3.) disfigurement; 4.) death; 5.) injuries relating to temperature or weather conditions, including hypothermia, frostbite, dehydration, and heat exhaustion; 6.)injury from the use or non-use of sports equipment; 7.) injury during travel to, from, and during RSCCD Athletic Activities; 8.) injury due to the negligent or intentional acts or omissions of college personnel, teammates, participants, officials, spectators, or others; and 9.) injury due to the inaccessibility of emergency medical care or negligent medical care in the treatment of an injury.

I am aware of the risks, dangers, and hazards of RSCCD Athletic Activities and personally and completely accept all risks associated with RSCCD Athletic Activities, including those listed above as well as those not specified, both anticipated and unanticipated, and including those which may result in death, injury, illness, damage to property, and injury to others.

Because of the potential risks involved, I acknowledge the importance of following, and agree to follow, all rules, and regulations pertaining to RSCCD Athletic Activities and my coaches', and athletic trainers' instructions regarding rules, techniques, training, equipment, and injuries. I understand that violation of such rules and instructions may result in injury to me or my opponent. I further understand that even when complying with all rules and instructions regarding RSCCD Athletic Activities and my safety equipment, there is nevertheless a significant risk of injury, including that which is inherent in sports. I agree to report all injuries to the athletic trainer, and I acknowledge and agree that I am responsible for the follow-up care and treatment regarding to my injuries, under the athletic trainer's supervision.

In consideration for being permitted to participate in RSCCD Athletic Activities, I hereby release Rancho Santiago Community College District, its trustees, officers, employees, agents, representatives, coaches, athletic trainers, and volunteers (the "Releasees") from, and waive and covenant not to sue the "Releasees" for, any and all claims, demands, losses, liabilities, obligations, damages, causes of action, and costs (including attorney fees) that arise out of or in connection with RSCCD Athletic Activities, including claims arising out of the negligent acts of the "Releasees". I further agree to indemnify and hold harmless the "Releasees" against any and all claims, and all defense costs (including attorney fees) relating thereto, brought by me or any party on my behalf relating to RSCCD Athletic Activities, or brought by any third party relating to any injury or loss allegedly caused by my negligent or intentional acts or omissions relating to RSCCD Athletic Activities.

I represent and warrant that I have carefully read and understand the terms of this agreement and that I have entered into this agreement knowingly, voluntarily, and of my own free will; and intend to abide by its provisions without exception.

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian (If student is under the age of 18) Date

Rancho Santiago Community College District
ATHLETICS

Student-Athlete Authorization/Consent for the Release of Protected Health Information

(Please Print)
Student/Athlete Name: _____

Address: _____City/Zip: _____

Phone #: _____ Date of Birth: _____

Sport(s): _____Student ID #: _____

I hereby authorize Rancho Santiago Community College District/Department of Intercollegiate Athletics to release my protected health information. Protected health information may include:

- Injury or illness relevant to past, present or future participation in intercollegiate athletics at Rancho Santiago Community College District.
- Information contained in my personal medical record unrelated to my participation in intercollegiate athletics at Rancho Santiago Community College District.
- Information concerning my medical status, medical condition, injuries, prognosis, diagnosis and other related personally identifiable health information, including injury reports, test results, x-rays, progress reports and any other documentation regarding my health status.

Authorization is granted for release of my protected health information to:

- My parents/guardian and/or spouse for the purpose of assisting me in making healthcare decisions while I am a student-athlete.
- The coaches, assistant coaches, and other athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete.
- Student athletic trainers and other students who are participating in the provision of sports medicine healthcare to assist and participate in the provision of healthcare to me while I am a student-athlete.
- Athletic counselor and academic departments within Rancho Santiago Community College District for the purpose of making decisions regarding my ability and suitability to perform academically while I am a student-athlete.
- Applicable insurance providers for the purpose of processing insurance claims while I am a student-athlete.
- Be transferred along with emergency contact information to an emergency card that will be carried by the head coach to be used in the event of accident or injury during athletic participation.
- Medical personnel for the purposes of continuity of care.

I understand that unless revoked by me in writing, this authorization will automatically expire two (2) years from the date it was signed.

You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or payment.

1. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. Any revocation will not be effective as to information already disclosed in reliance on the authorization. You can revoke this authorization by delivering a dated and signed letter to the Athletic Training Department.
3. Rancho Santiago Community College District will not receive compensation for its use or disclosure of your protected health information.
4. I understand that I may inspect or copy any information to be used or disclosed under this authorization.

Student/Athlete's Signature:_____ Date: _____

(If student is under 18 years of age)
Parent or Legal Guardian Signature: _____ Date: _____

Rancho Santiago Community College District
ATHLETICS

☐ SANTA ANA COLLEGE ☐ SANTIAGO CANYON COLLEGE

ACKNOWLEDGEMENT OF HEALTH SCREENING

This is to certify that I have had no major illness or injuries since my last health screening and I feel that I am physically able to practice and compete in intercollegiate athletics. If at any time during my intercollegiate participation, I feel that I am unable to compete or practice due to injury or illness, it is **MY RESPONSIBILITY TO NOTIFY** the medical staff and head coach immediately.

I am aware that I am obtaining a pre-participation athletic health screening, which will allow me to participate in intercollegiate athletics. I realize that the health screening is not as thorough as a physical exam and should not be assumed to be a complete physical exam.

NAME OF ATHLETE_____

SIGNATURE OF ATHLETE _____ **DATE** _____

IF UNDER 18 YEARS OLD:
SIGNATURE OF PARENT/LEGAL GUARDIAN _____ **DATE** _____

CONSENT TO TREAT

I give permission for the Host Certified Athletic Trainer(s) to evaluate, provide necessary treatment and/or referral to a physician for any injuries or illnesses that occurs as a result of my participation on an intercollegiate athletic team offered through the Rancho Santiago Community College District. This participation may include practices, competition and/or traveling with an intercollegiate athletic team at Santa Ana College or Santiago Canyon College.

NAME OF ATHLETE_____

SIGNATURE OF ATHLETE _____ **DATE** _____

IF UNDER 18 YEARS OLD:
SIGNATURE OF PARENT/LEGAL GUARDIAN _____ **DATE** _____

Rancho Santiago Community College District
ATHLETICS

Returning Student Athlete Health History Form

☐ SANTA ANA COLLEGE ☐ SANTIAGO CANYON COLLEGE

The information contained in this medical history form will only be used by Athletic Training Staff of Rancho Santiago Community College District for the purpose of determining if you pose a health threat/risk to yourself or others as a result of your participation in intercollegiate athletics at Santa Ana/Santiago Canyon College respectively. This information with remain *CONFIDENTIAL* at all times.

*(Please **TYPE On-Line** or print clearly in **BLUE** or **BLACK INK ONLY!**)*

NAME _____STUDENT ID #_____

ADDRESS_____CITY_____ZIP_____

HOME#_____CELL#_____WORK#_____

DATE OF BIRTH _____ AGE _____ YEAR OF ELIGIBILITY: ☐FRESHMAN ☐SOPHOMORE

SEX: ☐MALE ☐FEMALE SPORT(s):_____

RETURNING ATHLETE QUESTIONAIRE

□ YES □ NO 1. Do you have any new medical condition/illness since your most recent season of intercollegiate competition?
A. If yes, did it require the care of a physician? Explain._____

□ YES □ NO 2. Have you sustained any new orthopedic injuries since your most recent season of intercollegiate competition?
A. If yes, did it require the care of a physician? Explain._____

□ YES □ NO 3. Do you have any previous medical conditions/injuries that have affected you since your most recent season intercollegiate competition?
A. If yes, Please explain_____

□ YES □ NO 4. Do you have any concerns about your health that may affect your ability to participate in intercollegiate athletics at Santa Ana/Santiago Canyon College during the upcoming season?
A. If yes, Please explain._____

MEDICATION

Please list ALL prescription and over-the-counter medications that you are CURRENTLY taken or have taken in the past year (1) and for what purpose:

MEDICATION	PURPOSE	DOSAGE	DATE(s)

SURGERY

If you have had surgery or been under the care of a physician for any medical condition in the past twelve (12) months that has restricted your physical activity or athletic participation in any way, you must provide Santa Ana/Santiago Canyon College Athletic Training Department with a written release from the attending physician allowing participation in activities related to your condition and the specific sport you intend to participate in prior to ANY conditioning, practice, or competition. If you have any questions or concerns please contact the Athletic Trainer at your affiliate school.

Santa Ana College

Gary Kinney 714.564.6941 Kinney_Gary@sac.edu
Nora Schug 714.564.6940 Schug_Nora@sac.edu

Santiago Canyon College

Kelsey Bains 714.628.4704 Bains_Kelsey@sccollege.edu

Please describe below any further injury information of which you have knowledge, even if not specifically required by or requested on this form.

I have previously warranted and represented to Rancho Santiago Community College District Athletic Training Department that I have completed a *"New Student-Athlete Health History Form"* and have been examined by a Physician who cleared me for athletic participation. Recognizing that my true physical condition is dependant upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that: I have fully disclosed in writing my prior medical history, Student Athlete Health History Form was fully accurately completed; all my present symptoms, complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to and discussed with Rancho Santiago Community College District Athletic Training Department and the physician who cleared me for athletic participation.
I, the undersigned, hereby acknowledge, affirm, and represent that all statements on the above pages are complete, true, and accurate to the best of my knowledge and that no answers or information have been withheld. If any information and/or statements are false and/ or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare, and the health and physical welfare of others, may be jeopardized as a result and that I or others may suffer physical harm.

NAME OF ATHLETE_____

SIGNATURE OF ATHLETE_____ **DATE** _____

IF UNDER 18 YEARS OLD:
SIGNATURE OF PARENT/LEGAL GUARDIAN _____ **DATE** _____

Rancho Santiago Community College District
ATHLETICS

☐ SANTA ANA COLLEGE ☐ SANTIAGO CANYON COLLEGE

Pre-Participation Physical Evaluation

ID NUMBER _____ **SPORT(s)** _____

NAME _____ **DATE OF BIRTH** _____

LAST FIRST M.I

HEIGHT _____ WEIGHT _____ **BP** _____/_____ **PULSE** _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (males only)		
Hernia		
Skin		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

RECOMMENDATIONS AND DAGNOSIS: _____

EXAMINING PHYSICIAN (PRINT) _____ **, M.D., D.O., or PA-C** **DATE** _____

ADDRESS _____ **PHONE** _____

_____No Athletic Participation
_____Limited Athletic Participation: _____
_____Cleared after completing evaluation/ rehabilitation for: _____
_____Full Clearance

_____ **, M.D., D.O., or PA-C**
Examining Physicians/Physician Assistant Signature

MEDICAL OFFICE STAMP

NOTE: This document must be signed by a **Licensed Medical Doctor/Physician Assistant** within the state of California.

Rancho Santiago Community College District

SANTA ANA COLLEGE ATHLETICS

Dear Athlete:

Enclosed you will find insurance information and insurance verification forms which **MUST** be thoroughly completed by you and returned to the Certified Athletic Trainers prior to the time of your pre-participation health screening.

If these forms are not properly and accurately completed, it could result in the loss of your eligibility to compete. Please do not leave any questions blank.

The following forms are included in your packet:

- Insurance Verification Packet

Please provide a photocopy of the front and back of your current Medical Insurance Card

If you have any questions, please contact the Certified Athletic Trainers.

Thank you for your cooperation.

Gary T. Kinney, M.A., ATC
Certified Athletic Trainer
(714) 564-6941

Nora E. Schug, M.S., ATC
Certified Athletic Trainer
(714) 564-6940

Rancho Santiago Community College District
ATHLETICS

Athlete Acknowledgement of Insurance Reporting

The Athletic Department at Rancho Santiago Community College District is concerned with the health care of all participating athletes. The Athletic Department **WILL NOT** be responsible for any pre-existing injury or any operations not covered by our insurance. Medical expenses due to illness **ARE NOT** covered by the Rancho Santiago Community College District Athletic Insurance Policy.

In order for all athletes to receive complete medical benefits from the health care personnel, the following procedures **MUST BE FOLLOWED:**

1. Upon receiving **ANY** injury during a practice or game, (no matter how slight), the athlete **MUST REPORT IMMEDIATELY** to the Certified Athletic Trainer or Physician. If referred to a hospital, physician or emergency clinic, the athlete will need to assist in filing insurance claim forms.

2. If emergency treatment is required while an athlete is away from campus, it is the responsibility of the coach to contact the Host School's Certified Athletic Trainer to ensure that the athlete receives the necessary treatment. If a bill is received, a copy **MUST** be given to the athletic training personnel immediately upon return to your affiliate school (Santa Ana/Santiago Canyon College).

3. Referrals to the team physician **can only be made by the Certified Athletic Trainer.** Any coach who refers an athlete to an outside physician without the approval of the Team Physician or the Certified Athletic Trainer **MAY** be held responsible for all bills incurred.

4. In order for us to better serve you, we ask that you provide for your medical file a **photocopy** of the front and back of your medical insurance card. This will allow for faster, more accurate referrals for medical care. **It is the athlete's responsibility to contact the Certified Athletic Trainers if any changes occur in the athlete's insurance coverage.**

I give my permission for the Certified Athletic Trainers and Physicians who have evaluated/examined me while I am a student athlete at Santa Ana College/Santiago Canyon College to obtain information from other physicians, hospitals, therapists, medical allied groups etc. to have a better understanding of any injuries or illnesses which I may incur or develop.

NAME OF ATHLETE_____**SPORT(s)** _____

SIGNATURE OF ATHLETE _____**DATE** _____

IF UNDER 18 YEARS OLD:
SIGNATURE OF PARENT/LEGAL GUARDIAN_____**DATE** _____

Rancho Santiago Community College District
ATHLETICS

Intercollegiate Athletic Insurance Information

As an athlete at Santa Ana/Santiago Canyon College, you should understand the nature of the intercollegiate athletic insurance policy that the college provides in case you are injured while participating as an athlete. We feel it is important that you understand the type of policy that we have prior to signing this form.

The most common type of athletic insurance used by colleges today is "excess" or "secondary" insurance. This means that our insurance coverage only goes into effect after **ALL** other insurance you might have yourself through work, parents, and/or spouse have been exhausted.

With the new Health Care Reform laws in place, insurance companies can insure dependants until age 26. Insurance companies can and will check on other insurance coverage, but between outside or "primary" insurance coverage and the athletic insurance coverage through Rancho Santiago Community College District, you may possibly be covered 100%. However, insurance companies **DO NOT ALWAYS PAY ALL BILLS, SO YOU, AS THE PATIENT ARE HELD RESPONSIBLE FOR ALL BILLS INCURRED**. It is important that you cooperate with the athletic department to the fullest in order for bills to be paid.

The policy covers up to $25,000 maximum, and the injuries will have to be treated within 120 days from the date of the injury. Coverage extends up to 365 days from the date of injury. **Benefits are not provided for the following:**

1. Orthopedic appliances, unless prescribed by a physician
2. Pre-Existing conditions
3. Illnesses in general
4. Injury incurred during the transportation to an event except those occurring while being transported in a school vehicle.
5. Only injuries to sound teeth are covered, orthodontics will not be covered.

If you are injured in an "official" (supervised) practice or game, **you are responsible for submitting your medical bills to your primary or private insurance company *FIRST***. After that insurance company has paid its share, the balance of the bills will then be submitted to the athletic insurance company. **Remember:** Doctors and hospitals will hold you responsible for all payments until the insurance companies pay. Lack of cooperation with our department may result in the ***loss of your credit rating***.

Football, Soccer and Wrestling has a ***$100.00*** deductible per injury. All **other sports** have a ***$50.00*** deductible per injury.

By signing this form I acknowledge that I have read the information regarding the intercollegiate athletic insurance policy and have been made aware of the coverage. I will provide accurate information regarding any other insurance under which I might be covered.

NAME OF ATHLETE_____**SPORT(s)** _____

SIGNATURE OF ATHLETE _____**DATE** _____

IF UNDER 18 YEARS OLD:
SIGNATURE OF PARENT/LEGAL GUARDIAN_____**DATE** _____

Rancho Santiago Community College District
ATHLETICS

VERIFICATION OF PRIMARY INSURANCE

Name of Athlete_____ ID#_____
Address_____City/Zip_____
Phone #: Cell #: DOB:

EMERGENCY CONTACT INFORMATION

Contact #1
NAME: _____RELATIONSHIP:_____
ADDRESS (if different from personal address)
STREET:_____ CITY:_____ ZIP: _____
HOME PHONE#: CELL#: WORK #:

Contact #2
NAME: _____RELATIONSHIP:_____
ADDRESS (if different from personal address)
STREET:_____ CITY:_____ ZIP: _____
HOME PHONE#: CELL#: WORK #:

Do you have Medical Insurance: ☐ Yes ☐ No

Insurance coverage through: ☐ Parent ☐ Self ☐ Spouse Type of Coverage: ☐ Individual ☐ Through Employer

Name of Policyholder (parent/self/spouse):_____DOB:_____
Address of Policyholder: _____
Policyholder Contact Number: _____SSN of Policyholder: _____

Employer's Name (if applicable): _____
Insurance Company Name & Address: _____
Customer/Member Services Phone#_____

Type of Plan: ☐PPO ☐HMO ☐Other
Subscriber/Membership #_____Policy/Group#_____

Are you required to go to your own Primary Doctor? (HMO/PCP) ☐ Yes ☐No
Name of Doctor:_____ Phone_____
Name of Clinic:_____ Phone_____

I hereby certify that the foregoing answers I have provided to the stated questions are true, complete and correct to the best of my knowledge.

I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the student-athlete to disclose, when requested to do so, all information with respect to injury, medical history, consultation and treatment. A copy of this authorization shall be considered as effective and valid as the original.

NAME OF ATHLETE_____SPORT(s) _____

SIGNATURE OF ATHLETE _____DATE _____

IF UNDER 18 YEARS OLD:
SIGNATURE OF PARENT/LEGAL GUARDIAN_____DATE _____

Rancho Santiago Community College District
ATHLETICS

Athletic Insurance Information

Please attach a **COPY** of **BOTH SIDES** of your insurance card(s) here