

Returning Student-Athletes and Parents (Athletes – Please keep this page for information)

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. NWAC Athletic Questionnaire/Recruiting Disclaimer

This form contains all required NWAC 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 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 student's primary insurance. For these purposes, the primary insurance is your personal insurance which may be coverage through a parental policy. The CCS Athletic Department is intended to pay any deductibles the primary insurance or athletic insurance does not pay. Any student-athlete who sustains an injury that occurred during supervised participation (when a coach is present) during the season 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 athletic insurance policy is available upon request of the 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 PRIOR TO THE FIRST PRACTICE OF THE YEAR!

Return all forms to **SFCC** if you are competing in any of the following sports:

- Baseball
- Basketball-Women
- Soccer - Men
- Softball
- Volleyball

Nancy.Zacher@ccs.spokane.edu ■ 509 533-3630

Spokane Falls Community College * MS 3070
3410 W Fort George Wright Drive
Spokane, WA 99224-5288

Return all forms to **SCC** if you are competing in any of the following sports:

- Basketball-Men
- X-Country-M/W
- Golf-M/W
- Soccer-Women
- Tennis-M/W
- Track & Field-M/W

Wendy.Irish@ccs.spokane.edu ■ 509 533-7230

Spokane Community College * MS 2050
1810 N Greene Street
Spokane, WA 99217-5399



Northwest Athletic Conference 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	<input type="checkbox"/> SCC	<input type="checkbox"/> SFCC	<input type="checkbox"/> BOTH	SPORT(S)	SCHOOL YEAR
FULL NAME					<input type="checkbox"/> MALE <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you participated in an intercollegiate PRACTICE since high school?	<input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, name the team
When was the last time you participated?	Have you notified the team you are leaving? <input type="checkbox"/> YES <input type="checkbox"/> NO

LETTER OF INTENT		
Have you ever signed a Letter of Intent? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, for what sport?	
College	City/State	Year:

AMATEURISM	
Have you participated on or tried out for a professional team?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever played with, received payment from, or signed a contract to play with a professional team?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you received any other (non-athletic) scholarship and/or aid from this college for this academic year?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Since your decision to attend, have any friends/relatives also chosen to attend?	<input type="checkbox"/> YES <input type="checkbox"/> 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.

NWAC RECRUITING DISCLAIMER

In accordance with the NWAC Code Book (Article VI, Section 2), athletic recruiting is only allowed in the states of **Washington, Idaho, Oregon, Montana, Alaska, Hawaii, California, Nevada, Utah or Wyoming and the province of British Columbia**. Student-athletes whose home residence is outside the aforementioned contiguous states must submit an NWAC Athletic Questionnaire and Recruiting Disclaimer to the conference office. Passed 6/15/15; Effective 7/1/15

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 NWAC 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 NWAC office.

STUDENT-ATHLETE'S SIGNATURE _____ DATE _____

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



MEDICAL HISTORY UPDATE FORM

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 #

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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 OF THE FOLLOWING?

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

FULL NAME (PRINT) _____

LAST

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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					<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you ever had anemia?					<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Do you have sickle cell trait/anemia?					<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Do you have or have you ever had hypoglycemia (low blood sugar)?					<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Do you have a vision defect in either one or both eyes? If YES, please specify.					<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Do you wear glasses?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, do you wear them during athletic activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Do you wear contact lenses?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, do you wear them during athletic activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Do you wear any dental appliances?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, do you wear them during athletic activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Do you have a hearing defect? If YES, please specify and list any hearing aids worn:					<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Have you had either a gain or loss of ten pounds or more in the past 12 months? Specify:					<input type="checkbox"/> YES	<input type="checkbox"/> 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:					<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EAI)? If YES, what medication(s)					<input type="checkbox"/> YES	<input type="checkbox"/> NO

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

Aspirin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Penicillin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Acetaminophen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bee Stings	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Codeine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Erythromycin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Novocain or other anesthetics	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Iodine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sulfa Drugs	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ibuprofen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tetnus antitoxin or serums	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Latex	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If YES, please list those allergies here:										<input type="checkbox"/> YES	<input type="checkbox"/> 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Menstrual Cramps	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Scanty Flow	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Painful Menstruation	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Irregular Periods	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Excessive Flow	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Are currently taking Birth Control Pills?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, what type are you taking?						

FULL NAME (PRINT) _____

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E. EATING DISORDERS:

	Use this column to briefly explain YES answers		
1. Diagnosis of anorexia? If YES , when and where?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Diagnosis of bulimia? If YES , when and where?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. A problem with food bingeing?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Do you sometimes or often induce vomiting after eating?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Taken laxatives to lose weight?		<input type="checkbox"/> YES	<input type="checkbox"/> 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?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Chronic injury (ex, Tendonitis) that has limited your athletic participation?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Visited a health care provider due to a condition that limited your athletic participation?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Participated in physical therapy?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Been treated by a chiropractor, massage therapist, or acupuncturist?		<input type="checkbox"/> YES	<input type="checkbox"/> 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) _____

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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 _____



ATHLETE'S INSURANCE INFORMATION FORM

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.**

FULL NAME (PRINT) _____

SSN #

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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 _____



STUDENT-ATHLETE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

FULL NAME (PRINT) _____ SID#

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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

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) _____