THE EVERGREEN STATE COLLEGE
Athletics Pre-Participation Packet

Welcome to The Evergreen State College Athletics Program! Please fill out the enclosed forms listed below:

1. **Patient's Personal Information and Health History Form**
2. **Insurance and Emergency Information/Informed Consent Form**
3. **Assumption of Risk, Release of Liability, Indemnification and Publicity Release**
4. **Physician Exam Clearance Form**
   This exam must be done after June 1st.

These items must be complete before final clearance. If any forms are missing, it may take up to three days to clear your physical. Make sure to sign all spaces needing a signature!!!!!!

If you have any questions concerning the physical forms, contact the TESC Head Athletic Trainer at (360) 867-6587 or your sports coaching staff.

Upon completion, these forms must be returned to:

Head Athletic Trainer
College Recreation Center 122
The Evergreen State College
2700 Evergreen Parkway NW
Olympia, WA 98505

Patient's Personal Information and Health History Form

Name: ______________________________ Social Security #: ________________ Date: ____________
Last **First**
Home Address: _________________________ City: ______________ State: _____ Zip: ____________
Phone: ____________________________ Cell: _______________________
Email: ______________________________________
School Address: ________________________ City: ______________ State: _____ Zip: ____________
Phone: ____________________________ Cell: _______________________

Please answer each of the following questions by placing a check in the appropriate box. Include all relevant information.

Year of Eligibility:
- ❑ Freshman
- ❑ Sophomore
- ❑ Junior
- ❑ Senior

Please check all the varsity sports in which you plan to participate.
- ❑ Cross Country
- ❑ Men's Basketball
- ❑ Women's Basketball
- ❑ Men's Soccer
- ❑ Women's Soccer
- ❑ Track
- ❑ Volleyball
- ❑ Other: ____________________

Family History
Has any grandparent (GF, GM), parent (F, M) or sibling (B, S) experienced:

Sudden death before age 50:	☐No ☐Yes Who___
Alcoholism:	☐No ☐Yes Who___
Anemia (including Sickle Cell):	☐No ☐Yes Who___
Asthma:	☐No ☐Yes Who___
Birth Defects:	☐No ☐Yes Who___
Bleeding Disorder:	☐No ☐Yes Who___
Cancer (including Leukemia):	☐No ☐Yes Who___
Diabetes:	☐No ☐Yes Who___
Emphysema:	☐No ☐Yes Who___
Epilepsy:	☐No ☐Yes Who___
Glaucoma:	☐No ☐Yes Who___
Heart Disease:	☐No ☐Yes Who___
High Blood Pressure:	☐No ☐Yes Who___
Kidney Disease:	☐No ☐Yes Who___
Liver Disease:	☐No ☐Yes Who___
Mental Illness:	☐No ☐Yes Who___
Migraine Headaches:	☐No ☐Yes Who___
Tuberculosis:	☐No ☐Yes Who___
Stomach Disease:	☐No ☐Yes Who___
Stroke:	☐No ☐Yes Who___
Suicide:	☐No ☐Yes Who___
Other Serious Disease:	☐No ☐Yes Who___

Allergies
Are you allergic to any of the following:

Penicillin:	☐No ☐Yes
Sulfa:	☐No ☐Yes
Other antibiotics:	☐No ☐Yes
If so, what?	____________________
Any other medications:	☐No ☐Yes
If so, what?	____________________
Any foods:	☐No ☐Yes
If so, what?	____________________

Personal History
Do you consume any of the following:

Cigarettes:	☐No ☐Yes
Other forms of tobacco:	☐No ☐Yes
Beer or wine:	☐No ☐Yes
Other alcoholic beverages:	☐No ☐Yes
If so, how much of each?	____________________
Recreational drugs?	☐No ☐Yes
If so, what?	____________________

Personal questions:

Are you on a special diet?	☐No ☐Yes
Have you lost weight recently?	☐No ☐Yes
Are you satisfied with your weight?	☐No ☐Yes
Do you have an eating problem?	☐No ☐Yes
Do you have difficulty sleeping?	☐No ☐Yes

Medications
Are you taking any medications? ☐No ☐Yes
Have you ever taken:

Birth control:	☐No ☐Yes Date____
Blood pressure medication:	☐No ☐Yes Date____
Thyroid medication:	☐No ☐Yes Date____
Tranquilizers or sedatives:	☐No ☐Yes Date____
Laxatives or Ipecac:	☐No ☐Yes Date____
Other: ____________________	☐No ☐Yes Date____

SYSTEM REVIEW

Do you have any of these complaints now?

General

Aches & Pains:	☐No ☐Yes
Chills:	☐No ☐Yes
Easy bruising:	☐No ☐Yes
Fever:	☐No ☐Yes
General Weakness:	☐No ☐Yes
Memory Loss:	☐No ☐Yes
Swollen Glands:	☐No ☐Yes

Head

Blurred vision *(not corrected)*:	☐No ☐Yes
Double vision:	☐No ☐Yes
Eye pain:	☐No ☐Yes
Halos around lights:	☐No ☐Yes
Light flashes:	☐No ☐Yes
Buzzing/ringing in ears:	☐No ☐Yes
Ear pain:	☐No ☐Yes
Drainage from ear:	☐No ☐Yes
Hearing difficulty or deafness:	☐No ☐Yes
Nose bleeds *(not due to injury)*:	☐No ☐Yes
Sinus trouble:	☐No ☐Yes
Difficulty swallowing:	☐No ☐Yes
Mouth, tooth, or tongue problems:	☐No ☐Yes
Persistent hoarseness:	☐No ☐Yes
Severe headaches:	☐No ☐Yes
Other:________________	☐No ☐Yes

Chest, Heart, and Lungs

Chest pain or pressure:	☐No ☐Yes
Unusual heartbeat:	☐No ☐Yes
Coughing up blood:	☐No ☐Yes
Frequent cough:	☐No ☐Yes
Shortness of breath:	☐No ☐Yes
Wheezing:	☐No ☐Yes
Night sweats:	☐No ☐Yes
Poor exercise tolerance:	☐No ☐Yes
Other: ________________	☐No ☐Yes

Gastrointestinal

Abdominal pain/cramps:	☐No ☐Yes
Abdominal swelling:	☐No ☐Yes
Indigestion or heartburn:	☐No ☐Yes
Nausea or vomiting:	☐No ☐Yes
Poor appetite:	☐No ☐Yes
Change in bowel habits:	☐No ☐Yes
Constipation:	☐No ☐Yes
Diarrhea:	☐No ☐Yes
Black, tar-like bowel movements:	☐No ☐Yes
Blood in stool:	☐No ☐Yes
Other: ________________	☐No ☐Yes

Women's Health

Breast lumps:	☐No ☐Yes
Other breast problems:	☐No ☐Yes
Vaginal bleeding (not period):	☐No ☐Yes
Vaginal discharge:	☐No ☐Yes
Change in periods:	☐No ☐Yes
Pain with periods:	☐No ☐Yes
Pain not associated with periods:	☐No ☐Yes
Pain with intercourse:	☐No ☐Yes
Possibly pregnant:	☐No ☐Yes
Other: ________________	☐No ☐Yes

Men's Health

Breast lump:	☐No ☐Yes
Discharge from penis:	☐No ☐Yes
Sore on penis:	☐No ☐Yes
Lump in testicles:	☐No ☐Yes
Difficulty having erections:	☐No ☐Yes
Other: ________________	☐No ☐Yes

Neuromuscular

Difficulty with balance:	☐No ☐Yes
Dizzy spells:	☐No ☐Yes
Fainting spells:	☐No ☐Yes
Speech difficulty:	☐No ☐Yes
Weakness in arm or leg:	☐No ☐Yes
Other: ________________	☐No ☐Yes

Bones & Joints

Back pain:	☐No ☐Yes
Loss of muscle strength:	☐No ☐Yes
Lump on bone:	☐No ☐Yes
Lump or swelling in muscle:	☐No ☐Yes
Painful joints:	☐No ☐Yes
Swollen joints:	☐No ☐Yes
Other: ________________	☐No ☐Yes

Endocrine

Too cold most of the time:	☐No ☐Yes
Too warm most of the time:	☐No ☐Yes
Thirsty most of the time:	☐No ☐Yes
Unusually jumpy/nervous:	☐No ☐Yes
Unusually tired/sluggish:	☐No ☐Yes

Operations & X-rays

Appendix removal:	☐No ☐Yes Date____
Hernia (rupture):	☐No ☐Yes Date____
Other:	☐No ☐Yes Date____
X-rays:	☐No ☐Yes Date____

If yes, what and why:____________________

DIAGNOSED DIFFICULTIES

Do you now have, or have you in the past had any of the following? Leave blank anything you are uncertain about.

Condition	Response
Concussion:	☐No ☐Yes Date_____
Migraine headaches:	☐No ☐Yes Date_____
Epilepsy or convulsions:	☐No ☐Yes Date_____
Heat related illness:	☐No ☐Yes Date_____
Glaucoma:	☐No ☐Yes Date_____
Cataracts:	☐No ☐Yes Date_____
Blindness in either eye:	☐No ☐Yes Date_____
Ear infections:	☐No ☐Yes Date_____
Deafness:	☐No ☐Yes Date_____
Asthma:	☐No ☐Yes Date_____
Hay fever:	☐No ☐Yes Date_____
Chronic bronchitis:	☐No ☐Yes Date_____
Tuberculosis:	☐No ☐Yes Date_____
Abnormal electrocardiogram:	☐No ☐Yes Date_____
Heart murmur:	☐No ☐Yes Date_____
Rheumatic Fever:	☐No ☐Yes Date_____
High Blood Pressure:	☐No ☐Yes Date_____
Mononucleosis:	☐No ☐Yes Date_____
Hepatitis:	☐No ☐Yes Date_____
Stomach or duodenal ulcer:	☐No ☐Yes Date_____
Colon or bowel trouble:	☐No ☐Yes Date_____
Rectal trouble:	☐No ☐Yes Date_____
Hemorrhoids or piles:	☐No ☐Yes Date_____
Serious diarrhea:	☐No ☐Yes Date_____
Kidney or bladder infection:	☐No ☐Yes Date_____
Kidney stones:	☐No ☐Yes Date_____
Loss of kidney:	☐No ☐Yes Date_____
Other kidney disease:	☐No ☐Yes Date_____
Anemia:	☐No ☐Yes Date_____
Poor blood clotting:	☐No ☐Yes Date_____
Diabetes:	☐No ☐Yes Date_____
Overactive thyroid:	☐No ☐Yes Date_____
Underactive thyroid:	☐No ☐Yes Date_____
Shoulder injury:	☐No ☐Yes Date_____
Neck injury:	☐No ☐Yes Date_____
Ankle injury:	☐No ☐Yes Date_____
Back injury:	☐No ☐Yes Date_____
Knee injury:	☐No ☐Yes Date_____
Broken bone:	☐No ☐Yes Date_____
Stress fracture:	☐No ☐Yes Date_____
Arthritis:	☐No ☐Yes Date_____
Phlebitis:	☐No ☐Yes Date_____
Recurrent boils:	☐No ☐Yes Date_____
Other skin disease:	☐No ☐Yes Date_____
Serious depression:	☐No ☐Yes Date_____
Serious emotional problems:	☐No ☐Yes Date_____
Women	
Breast lumps:	☐No ☐Yes Date_____
Maternal DES exposure:	☐No ☐Yes Date_____
Menstrual difficulties:	☐No ☐Yes Date_____
Ovarian cyst:	☐No ☐Yes Date_____
Urinary tract infection:	☐No ☐Yes Date_____
Other:_______________	☐No ☐Yes Date_____
Age periods started:	_______
Last menstrual period:	Date________
Last pap smear:	Date________
Are you sexually active?	☐No ☐Yes
Are your periods regular?	☐No ☐Yes
Do you do self-breast exams?	☐No ☐Yes
Do you use birth control?	☐No ☐Yes
# of pregnancies:	________
# of miscarriages:	________
# of children:	________
Men	
Prostate trouble:	☐No ☐Yes Date_____
Testicular trouble:	☐No ☐Yes Date_____
Other:_______________	☐No ☐Yes Date_____
Are you sexually active?	☐No ☐Yes
Do you do self-testicular exams?	☐No ☐Yes
Do you use birth control?	☐No ☐Yes

Do you have any disease or condition not listed on this form? ☐No ☐Yes
If yes, please explain: ____

I, ____, the undersigned, herewith:

A. Understand that I must refrain from practice or play while ill or injured, whether or not receiving medical treatment and during medical treatment, until I am discharged from treatment or given permission by the clinical practitioner and Athletic Trainer to restart participation despite continuing treatment.
B. Understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me at the time of examination.
C. Give permission to the Health Service and Athletic Training Staff to discuss medical conditions pertaining to athletic participation.
D. Certify that the answers to the questions above are correct and true.

Signature: ____ Date: _______________

Insurance and Emergency Information/Informed Consent Form

Name: ______________________________________
Last **First**

Insurance Information:

Sex: ☐ Male ☐ Female Date of Birth: ___________ Age: ____

Do you currently have medical insurance? ☐Yes ☐No

Insurance Company: ______________________________ Phone:________________

Policy Holder Name: ______________________________

Policy Holder #: ____________ Group #: ____________ Member #: ____________

Are you employed? ☐Yes ☐No

Employer: ____ Phone:________________

Do you have medical insurance through your employer? ☐Yes ☐No

Emergency Contact Information:

Father/Guardian Name: ___________________________

Address: ___________________ City: _______________ State: _____ Zip: _________

Phone: __________________________ Cell: ________________________________

Mother/Guardian Name: ___________________________

Address: ___________________ City: _______________ State: _____ Zip: _________

Phone: _________________________ Cell: _________________________________

Other Emergency Contact Name: ___________________________

Address: ___________________ City: _______________ State: _____ Zip: _________

Phone: _________________________ Cell: _________________________________

Informed Consent:
I give permission to the Head Athletic Trainer to employ established emergency care, treatments and therapy as may be deemed professionally necessary or advisable in the evaluation and treatment of any illness and/or injury.

I hereby authorize THE EVERGREEN STATE COLLEGE Athletic Department to disclose my protected health care information to such emergency, hospital or doctors offices where medical care will be provided. I understand this information is protected by HIPPA or FERPA and I give authorization voluntarily and is not a condition of my participation in my sport. I understand that my insurance will serve as the primary insurance coverage and TESC insurance will be secondary insurance coverage.

Signature: ____ Date: _________________

Printed Name: ____

Assumption of Risk, Release of Liability, Indemnification and Publicity Release

I, the undersigned, in consideration for the opportunity to participate in THE EVERGREEN STATE COLLEGE Athletics Program, agree as follows:

1. Assumption of Risk. I understand and agree that the Program involves my participation in individual or team sports with other THE EVERGREEN STATE COLLEGE (TESC) students, and that such sports involve dangerous risks and hazards that may result in my injury or even death. I am aware of the risks and hazards of the particular Program in which I participate. I also understand and agree that the Program in which I will be involved may result in damage or loss to my personal property either due to the environment or my own acts or omissions or the acts or omissions of others. I understand and agree that I am solely responsible for the protection and security of my personal property. I knowingly and voluntarily assume all risks of participating in the Program, including but not limited to, injury sustained through forces of nature, falling, slipping, collisions, impacts or other causes and any other accident or illness that may occur arising from or related to my participation in the Program, and any damage or loss to my personal property. I agree to follow the policies, procedures and guidelines of TESC, and to engage in the Program in a safe and appropriate manner. I acknowledge that TESC encourages me to consult with my physician before participating in any Program, and to wear a medical alert bracelet or neck tag indicating any medical information I think appropriate.

2. Release of Liability and Indemnification. On behalf of myself, my heirs, legal representatives, and assigns, I release and agree to indemnify TESC, and its directors, officers, administrators, employees, volunteers, and other agents (all collectively referred to as "Releasees") from all claims, damages and other liability for any injuries, loss of life, property loss or other damage I may sustain arising from or related in any way to my participation in the Program (collectively referred to as "Claims"), even if arising out of the negligence on the Releasees. Provided, however, the provisions of this Section 2 do not apply to Claims against a Releasee arising out of such Releasee's intentional misconduct or gross negligence.

4. Photography/Publicity Release. I hereby give to TESC, my permission and all rights to copyright, use, publish, exhibit, display, broadcast or print (in any medium) my image, name and any interview comments or responses in connection with any TESC publication (whether in print, electronic or other form, and whether posted on the Internet or otherwise published) or in connection with any TESC promotional purpose. I understand I will receive no additional compensation or consideration for such permission and rights.

NOTE: READ CAREFULLY BEFORE SIGNING. THIS DOCUMENT CONTAINS A RELEASE OF CLAIMS.

I hereby affirm that I have voluntarily registered in and certify that I am cognizant of all the inherent dangers associated with participating in this activity. I have been informed that the College does provide limited insurance for my protection and acknowledge responsibility for providing additional insurance against these risks. I verify that I have no physical handicaps or impairments, which might inhibit my participation in this activity. I hereby assume all risks in connection with this activity and further release and hold harmless the State, College, coaches, administrators, athletic trainers, teammates and other agents for any harm, injury or damage which may befall me, whether foreseeable or not.

Participant Signature: ______________________________ Date: ______________

Printed Name: ______________________________________

Sport: ____________________

Physician Exam Clearance Form

Physical Examination

Name: ______________________________ Birth Date: __________

Sport: ______________________________

VIATAL:

Height: ___ft.____in. Weight: _______lbs. Resting Pulse Rate: ______BPM

Blood Pressure: _______ / _______

Recheck (if elevated): _______ / _______

Vision: Rt 20 /_______ Lt 20/_______ Corrected: YES NO

Pupils: EQUAL UNEQUAL

***Initials of practitioner(s) who performed the vitals:*_________**

ASSESSMENT:

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CLEARANCE:

☐ **Cleared without restrictions**

☐ **Cleared with Recommendation:**___________________________________

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☐ **NOT CLEARED** (PLEASE EXPLAIN): ______________________________

____

____

Physician Only:

Printed Physician's Name: __________________________ Fax: ____________________

Street Address: __________________________________ Phone: ____________________

City/State: ________________________ Check One: ☐ Physician

☐ Physician Assistant

☐ Nurse Practitioner

Signature for Clearance: ___________________________________ Date ___________