COMMODORES
ATHLETICS

Welcome to Gulf Coast State College Athletics!

Enclosed you will find the forms that are required for student-athlete participation in athletics at Gulf Coast State College (GCSC). All forms must be completed, signed and returned to the Athletic Trainer/ Athletic Office with appropriate supportive documentation before student-athletes can participate in GCSC related practices and games. Below is an outline of the forms following this page:

1. Athletic Training Room Information Form
    a. Student Information
    b. Emergency contact
    c. Local Address
2. Shared Responsibility Form
3. Social Security Number Disclosure Form
4. Athletic Insurance Information
    a. Explanation of GCSC Athletic Coverage
5. Insurance Verification Form
    a. Include copy of front and back of personal insurance cards
6. Disclosure of Health Information
    a. Allows GCSC Sports Medicine to discuss with other medical personal and insurance companies student-athlete's personal medical information
7. Medical Authorization and Assumption of Risk
8. Medical Health History Form
    a. Orthopedic History
    b. Health History Questionnaire
9. Athletic Physical Form
    a. MUST BE COMPLETED BY A PHYSCIAN

GCSC provides a supplemental insurance policy for athletic injuries only. GCSC insurance does not cover illness, dental exams, eye exams or injuries that occur outside athletics, or that occur prior to attending GCSC. Any student athlete covered under a parent/ guardian insurance company; this will fall under that student athlete's primary insurance. After your insurance has paid, GCSC insurance will cover the athletic related injuries. If the student-athlete has no insurance, the schools insurance will become the primary insurance for athletic injuries only. Any unpaid balances after the insurance company pays or denies a claim is the responsibility of the student-athlete.

If a student-athlete sees a doctor or other medical provider without notifying the college, the student athlete may be held financially responsible. It is the athlete and parent/legal guardian's responsibility to send all bills and explanation of benefits to the Athletics Office and/or Athletic Training staff at:

Wellness and Athletics Administrative Assistant
Gulf Coast State College Athletics
5230 W. Hwy 98
Panama City, FL 32401

Warm Regards,

Gulf Coast State College Athletics
Main Office: 850.872.3831

Athletic Training Room Information
Gulf Coast State College

Name_____ Sport_____
First Middle Last

Permanent Address _____
Street/Apartment# City State Zip Code

Student Athlete Cell Phone #:_____ Student Athlete Email: _____

Best way to contact (Circle one): Call Text Email

Emergency Contact:

_____
Name Relation Phone#

Year	Local Address	Updated Phone # and Emergency Contact
1		
2		
3		

Revised May 2019

SHARED RESPONSIBILITY FOR SPORTS SAFETY

Gulf Coast State College

Name:_____ Sport:_____

Participation in Gulf Coast State College athletics requires an acceptance of risk of injury. Your decision to participate in athletics at GCSC indicates your acceptance of this risk. In order to minimize this risk as a participant, you must be aware of and abide by certain procedures, safety rules, and guidelines. Sound conditioning and training programs are designed to help in the prevention of injury-rehabilitation programs are designed to enable recovery and return to participation safely. **Your responsibility to these programs is as important as your responsibility to learning and using proper skills, techniques, and the strategies for your sport. Any improper use, modification to or abuse of your equipment, or technique may result in serious, life threatening injuries or death.** Participation in sports is a risk for injuries that include but are not limited to, strains, sprains, contusions, concussions, head and neck injuries, paralysis, internal injury and death. Periodic analyses of injury patterns lead to refinements in the rules and other safety decisions, but safety cannot be legislated solely through a rulebook and equipment standards. All involved must share the responsibility for sport safety, and compliance with the rules means respect on everyone's part for the intent, spirit and purpose of the rule or guidelines. The GCSC Athletic Administration, Coaches, and Staff expressly condemn any act by GCSC Athletes to intentionally injure another player.

The undersigned herewith. *(Initial below)*

I. __Agree(s) to allow the GCSC Sports Medicine Staff to evaluate, treat and care for any injury or illness, which may occur to him/her.

II. __Understand(s) that he/she will refrain from practice or play while ill or injured, whether or not receiving medical treatment, and maintain medical treatment until he/she is discharged from treatment or is given permission by the GCSC Sports Medicine Staff to restart participation while continuing treatment.

III.__ Understand(s) that having passed the medical qualifying evaluation docs not necessarily mean that he/she is physically qualified to engage in athletics, only that the evaluation did not rind a medical reason to disqualify him/her at the time of said evaluation.

IV. __Agree(s) to report to the GCSC Sports Medicine Staff:

A. All injuries and illnesses sustained
B. Any change in injury or medical history
C. All medications (prescriptions, over the counter medicine and supplements) taken for any reason

V. __Gives consent for GCSC Sports Medicine Staff to release information to the coaching staff, emergency personnel, and other medical professionals as appropriate for the purpose of communicating the nature of and status of injury sustained and treatment.

VI. __I hereby acknowledge my shared responsibility for the risks of injury, which could occur as a result of my athletic participation.

_____ _____

Signature Student Athlete Date

_____ _____

Signature of Parent/Guardian Date

NOTIFICATION OF SOCIAL SECURITY NUMBER COLLECTION, USE, OR RELEASE FOR THE DEPARTMENT OF INTERCOLLEGIATE ATHLETICS

In accordance with Florida Statutes, Section 119.071(5)(a)(2), this notification serves to inform you of the purpose for the collection, use, or release of your Social Security Number (SSN) by the Gulf Coast State College (GCSC) Department of Intercollegiate Athletics.

The table below lists the purpose for the GCSC Department of Intercollegiate Athletics' collection, use, or release of SSNs and the statutory authority for such collection, use, or release:

PURPOSE	STATUTORY AUTHORITY
Insurance billing and collection activities for health services provided.	Fla. Stat. Sec. 119.071(5)

The collection, use, or release of your Social Security Number for the above purposes is imperative for the performance of the GCSC Department of Intercollegiate Athletics' duties.

Please note that this notification only lists the purpose for the collection, use, or release of your SSN by the GCSC Department of Intercollegiate Athletics. You may receive separate notifications from other divisions, departments, or units within GCSC regarding the collection, use, or release of your SSN by GCSC

By signing this document, you acknowledge the receipt of the above statement.

Name: _____

Signature: _____

Social Security Number: _____

Date: _____

Revised May 2019

To the Parents, Guardians and/or Caregivers of Gulf Coast State College Student-Athletes:

The Gulf Coast State College Sports Medicine Department provides care for all student-athletes for injuries that occur during their intercollegiate participation. We are sending out this letter to remind you of our policy and how we handle the cost and medical care provided to your son/daughter.

When your son/daughter receives medical care approved by our Athletic Training Staff or team physicians, your insurance will be billed for the services they received. **You will not be asked to pay for any charges that your insurance company does not pay.** Gulf Coast State College carries a secondary insurance and covers those out of pocket costs for you. You may however receive an explanation of benefits from your insurance company. This document IS NOT A BILL. This is simply a summary of the charges that were filed against your insurance policy for services rendered. When you receive one of these documents, we simply ask that you forward a copy of this to GCSC so that we can pay for the out of pocket costs. If for any reason you ever receive a bill from a medical provider, we also ask that you send us a copy of this document as well.

Some of you may receive an Explanation of Benefits (EOBs) from your primary insurance carrier, after your child suffered an injury at GCSC. For those documents already received, please send these to our insurance coordinator- via fax (850-873-3530, ATIN: Ray and Mandy), as soon as possible.

Here are a few examples or the types of service that you can expect to receive EOB's:

Surgeries	**Rehabilitation Services**	**Anesthesiology**
Doctor Visits	**CT Scans**	**Hospital Charges**
MRI's	**X-rays**	**Physical Therapy**

Should you have any questions or concerns regarding any documentation you receive from your insurance carrier, you are welcome to email those documents and your questions or concerns to Ray Stanquist (rjs1086@gulfcoast.edu). As always, you are welcome to give me a call directly and I will assist you with your questions and/or issues.

Sincerely,

Ray Stanquist M.Ed, LAT, ATC
Head Athletic Trainer
Gulf Coast State College
(850)769-1551 x3369
F: (850) 873-3530
rjs1086@gulfcoast.edu

Policy Holder Signature: _____ Student _____ Date: _____

Athlete Signature: _____ Date: _____

INSURANCE VERIFICATION

Gulf Coast State College Athletic Training

To maximize your benefits and expedite the care of your child, while he/she is away at school, GCSC Athletic Training asks that you please contact your insurance company and/or your employer's benefits office NOW to determine eligibility and coverage in the Panama City area.

ATHLETE NAME: _____ DOB: _____ SSN#: _____

I. Do you have health insurance? YES or NO

a. If yes, Insurance comp any: _____

b. Insurance comp any phone#: _____

c. Policy#: _____ Group #: _____

d. Policy Holder Name: _____ DOB: _____ SSN: _____

e. Phone# _____ Address _____

II. Do you have secondary health insurance? YES or NO

a. If yes, Insurance comp any: _____

b. Insurance comp any phone#: _____

c. Policy#: _____ Group #: _____

d. Policy Holder Name: _____ DOB: _____ SSN: _____

e. Phone# _____ Address _____

III. Do you have dental insurance? YES or NO

a. If yes, Insurance comp any: _____

b. Policy#/1D: _____ Group#: _____

c. Policy Holder Name: _____ DOB: _____ SSN: _____

d. Phone# _____ Address _____

IV. Do you have vision insurance? YES or NO

a. If yes, Insurance company: _____

b. Policy#/1D: _____ Group#: _____

c. Policy Holder Name: _____ DOB: _____ SSN: _____

d. Phone# _____ Address _____

PLEASE INCLUDE A COPY OF INSURANCE CARDS

****If for any reason your insurance gets terminated or there are any changes in your coverage you must notify us immediately. Failure to do so may result in you incurring out-of-pocket expenses. If you have any questions, please feel free to contact us at 850-872-3831. ****

_____ _____

Policy Holder's Signature Date

_____

Print Name

Revised May 201

STUDENT-ATHLETE CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Gulf Coast State College Athletic Training

I, _____ hereby authorize Gulf Coast State College and its athletic trainers, physicians, conference, and other health care personnel to disclose my health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to the following:

- Outside health care providers associated with the GCSC Athletics Department for the purpose of providing me with treatment and coordinating and managing my health care with others. Such outside healthcare providers include but are not limited to: Southern Orthopedics Specialists, Gulf Coast Regional Medical Center, Bay Medical Center, Gulf Coast Physical Therapy, First Choice Physical Therapy.
- Insurance companies associated with the GCSC Athletics Department for the purpose of collecting payment for the treatment and services provided to me by the College or by another provider. Such insurance companies include but are not limited to: Relation Insurance, Underwriter Mutual of Omaha.
- Scouts or representatives from any professional or amateur organization for the purposes of assisting the organization in making a determination as to the offering of employment.
- Officials of the Panhandle Conference, GCSC Athletics staff and administration, and the National Junior Collegiate Athletics Association (NJCAA) for the purpose of complying with the GCSC Athletics, Panhandle or NJ CAA policies or requirements regarding the reporting of injuries.

I understand that my injury/illness information is protected by federal regulations under the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without my consent under the Buckley Amendment. I understand that my signing of this Consent Form is voluntary, and that my institution will not condition any health care treatment or payment. I also understand that I am not required to sign this Consent Form in order to be eligible for participation in NJCAA or conference athletics.

This Consent Form expires at the time that my eligibility in intercollegiate athletics at Gulf Coast State College has exhausted, but I have the right to revoke it in writing at anytime by sending written notification to the Head Athletic Trainer at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

_____ _____

Signature of Student-Athlete Date

I, _____, of lawful age and being do hereby authorize the head coach, team physician(s) and/or athletic trainers (s) to release, verbally and/or in writing, to sports information and/or journalists, for the purpose related to press releases and/or articles, all information pertaining to injuries/illnesses that effect my sports participation.

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/ Guardian Date

Revised May 2019

MEDICAL AUTHORIZATION & ASSUMPTION OF RISK & RELEASE FORM
Gulf Coast State College

ATHLETE'S NAME:_____ SPORT: _____
(PLEASE PRINT)

ASSUMPTION OF ALL RISKS

I, on behalf of myself, understand that there are certain inherent risks involved in participating in athletics-related activity and understand that participation on the _____ team ("Program") and activities incidental thereto may result in property damage, injury and/or illness, permanent physical or mental impairment, or death to myself or others. I, on behalf of myself, accept and assume responsibility for all such risks relating to my participation in the Program and activities incidental thereto.

RELEASE OF ALL CLAIMS

In consideration of GCSC's agreement to allow myself to participate in the Program, I, on behalf of myself, do hereby voluntarily release, discharge, waive and relinquish any and all actions or causes of action for property damage, personal injury or wrongful death against THE GULF COAST STATE COLLEGE BOARD OF TRUSTEES, STATE OF FLORIDA, and FLORIDA BOARD OF GOVERNORS relating to GCSC's actions or omissions pursuant to this Medical Authorization or arising out of my participation in the Program or any activities incidental thereto, wherever or however the same may occur. It is my intention to exempt and relieve THE GULF COAST STATE COLLEGE BOARD OF TRUSTEES, STATE OF FLORIDA, and FLORIDA BOARD OF GOVERNORS and their respective officers, employees and agents, from liability for personal injury, property damage or wrongful death caused by negligence.

I, on behalf of myself, the undersigned, being 18 years of age or older, have read this Medical Authorization and Assumption of Risk and Release Form and understand all of its terms. I have been given an opportunity to ask questions about this matter and I execute it voluntarily and with full knowledge of its significance.

I acknowledge reviewing the Gulf Coast State College athletic injury, medical procedure, and insurance policy information. I have read and understand the College's procedures for securing medical assistance and payment of expenses for the covered athletic injuries.

SIGNATURE: _____
PARENT, GUARDIAN OR INSURANCE POLICY SUBSCRIBER (If under 18 years of age)

SIGNATURE: _____ Student Athlete (1st year)

_____ _____
Signature of Student-Athlete (2nd Year) Today's Date (Month/Day/Year)

_____ _____
Signature of Student-Athlete (3rd Year) Today's Date (Month/Day/Year)

Gulf Cost State College

Medical Health History

Name:_____Sport:_____
First Middle Last

Sex: Male ____ Female _____ Date of Birth: / / Age: _____ SSN#: _____

Local Address:_____(City)_____(State)_____ (Zip) _____

Cell Phone: (____) _____ E-Mail Address: _____

Emergency Contact:_____ Relationship to you: _____

Phone: (____) _____ Address: _____(City) _____ (State) _____ (Zip) _____

ALLERGIES/ DRUG, OTHER

☐ Codeine
☐ Other Drugs: _____
☐ Food
☐ Other: _____

☐ No Known Allergies
☐ Aspirin
☐ Penicillin
☐ Sulfa

PERSONAL HISTORY

	YES	NO	Date, If Yes		YES	NO	Date, if Yes
Anemia				Hepatitis			
Asthma				High Blood Pressure			
Bleeding Disorder				Kidney Disease			
Blood Clots				Loss Of Consciousness			
Blood in Stool				Ovarian Cyst			
Breast mass				Ulcer			
Cancer				PIO			
Depression				Seizures/ Convulsions/ epilepsy			
Diabetes mellitus				Sickle cell disease/ trait			
Eating disorder				Thyroid disease			
Fibroid				Tuberculosis/ positive PPD			
Heart Murmur				Other			

Family Medical History: Were you adopted? Yes □ No □ If no, complete below. List any **close relatives** who had the following:

☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ Stroke
☐ Drinking Problems
☐ High Blood Pressure
☐ High Cholesterol
☐ Depression

Health Behaviors	YES	NO
Do you perform regular breast/testicular exams?		
Do you smoke?		
Do you drink alcohol?		
Are you content with how you handle stress?		
Are you content with your current weight?		
Are you sexually active?		

This history form is confidential and will be kept in your medical record. No information may be released without your written consent, unless required by law.

CONSENT FOR TREATMENT (If under 18 years of age, parental consent is required): I authorize the health care providers to perform diagnostic and treatment procedures which are necessary in their judgment. I understand that I am responsible for charges incurred and authorize release of medical information to third party insurers for billing purposes.

_____ _____
Signature of Student Athlete Date

_____ _____
Signature of Parent/Guardian Date

FIRST YEAR ORTHOPEDIC QUESTIONNAIRE

Gulf Coast State College Athletic Training

NAME _____ SPORT _____

CERVICAL SPINE/ NECK		
Have you ever suffered an injury Y to your cervical spine and/or neck? **Date**	YES	NO
Were any diagnostic tests performed? X-Ray. MRI, CT Scan, Bone Scan (circle all that apply) **Date:**	YES	NO
Have you ever suffered an injury Y to your cervical spine and/or neck? **Date**	YES	NO
Have you ever had a 'Burner' or 'Stinger' and/or Bronchial Plexi surgery? **(circle** all that apply) **Date:**	YES	NO
Have you ever experienced numbness or tingling in your arms or finger? **Explain:**	YES	NO
SHOULDER/ UPPER ARM		
Have you ever suffered an injury to your shoulder and/or upper arm? (circle all that apply) Date:	YES	NO
Were any diagnostic tests performed X-Ray, MRI, CT scan. Bone Scan? (circle all that apply) Date:	YES	NO
Have you ever had surgery of any kind for a shoulder and/or upper arm? (Circle all that apply) Date:	YES	NO
ELBOW/ FOREARM		
Have you ever suffered an injury to your elbow and/or forearm? (Circle all that apply) Date:	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:	YES	NO
Have you ever had any surgery for an elbow and/or forearm? (circle all that apply) **Date:**	YES	NO
WRIST/HAND/FINGERS		
Have you ever suffered an injury to your wrist/hand, and/or fingers? (circle all that apply) Date:	YES	NO
Were any diagnostic test performed? X-Ray, MRI, CT Scan, Bone Scan? (Circle all that apply) **Date:**	YES	NO
Have you ever had surgery on wrist/hand, and/or fingers? **(Circle** all that apply) **Date:**	YES	NO
SPINE/ LOW BACK/ SACROILIAC JOINT		
Have you ever suffered an injury to your spine now back/ or sacroiliac joint? (circle all that apply) Date:	YES	NO
Were any diagnostic tests performed X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:	YES	NO
Have you ever had surgery of any kind for a spine now back/ sacroiliac joint? **(Circle** all that apply) **Date:**	YES	NO
Have you ever had numbness/tingling down one or both legs? **Explain**	YES	NO
HIP/ GROIN/ HAMSTRING/ QUADRICEPS		
Have you ever suffered an injury to your hip/groin/hamstring/quadriceps? **(Circle** all that apply) **Date:**	YES	NO
Have you ever had a hernia or a sports hernia? **(Circle** all that apply) **Date:**	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT scan, Bone Scan (circle all that apply) **Date:**	YES	NO
Have you ever had surgery for your hip/groin/hamstring/quadriceps? **(Circle** all that apply) **Date:**	YES	NO
KNEE/ PATELLA		
Have you ever suffered an injury to your knee or patella? (Circle all that apply) **Date:**	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) **Date:**	YES	NO
Have you ever had surgery for your knee/patella? (circle all that apply) **Date:**	YES	NO
Have you ever/ do you presently wear a knee brace? **What type? Which knee? Reason for wearing?**	YES	NO
ANKLE/ LOWER LEG		
Have you ever suffered from an injury to your ankle and/or lower leg? (Circle all that apply) **Date:**	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) **Date:**	YES	NO
Have you ever had surgery for your ankle and/or lower leg? (Circle all that apply) **Date:**	YES	NO
Do you presently tape your ankles/ wear ankle braces/ wear orthopedics? (Circle all that apply) **Describe:**	YES	NO
FOOT/ TOES		
Have you ever suffered from an injury to your foot and/or toes? (Circle all that apply) **Date:**	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) **Date:**	YES	NO
Have you ever had surgery for your foot and/or toes? (Circle all that apply) **Date:**	YES	NO

If you answered, "yes" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form. please explain in detail on following page.

I, the undersigned, hereby acknowledge affirm, and represent that all of the above statements are 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 understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student Athlete Signature: _____ **Date:** _____

PLEASE EXPLAIN ALL OF YOUR YES ANSWERS IN DETAIL BELOW

CERVICAL SPINE/NECK:
SHOULDER/ UPPER ARM:
ELBOW/ FOREARM:
WRIST/HAND/FINGERS:
SPINE/LOW BACK/ SACROILIAC JOINT:
HIP/ GROIN/ HAMSTRING/ QUADRICEPS:
KNEE/ PATELLA:
ANKLE/ LOWER LEG:
FOOT/TOES:

FIRST YEAR HEALTH HISTORY QUESTIONNAIRE

Gulf Coast State College Athletic Training

Name:_____ **Sport:**_____

CARDI0VASUCLAR RISK FACTORS		
Chest pain or shortness of breath during/after exercise?	YES	NO
Dizzy, lightheaded. and/or passed out during/after exercise?	YES	NO
Feeling of your heart racing or skipping beats during/after exercise?	YES	NO
Ever more tired than teammates/friends during exercise?	YES	NO
Ever been told you have a heart murmur?	YES	NO
Family member died or had heart problems and/ or sudden death before age of 50?	YES	NO
Ever been restricted or denied participation due to a heart issue?	YES	NO
Ever had an EKG or Echo? **Date:**	YES	NO
Ever been told you have high blood pressure or high cholesterol?	YES	NO
ALLERGIES		
Have you ever had an allergic reaction to food? **Explain**	YES	NO
Have you ever had an allergic reaction to any medications? **Explain**	YES	NO
Have you ever had an allergic reaction to an insect or pet? **Explain**	YES	NO
ASTHMA		
Have you ever been diagnosed with asthma or exercise induced asthma?	YES	NO
Are you taking any medications or an inhaler to control your asthma? **If so what prescription:**	YES	NO
HEAD INJURIES/CONCUSSIONS		
Have you ever suffered a head injury/ concussion (no matter how minor)? **Date:** _____ **How many:** _____	YES	NO
Have you ever been knocked out, hospitalized or lost your memory due to a head injury/ concussion?	YES	NO
Do you suffer from headaches? **How often?**	YES	NO
Are you taking any medication to control your headaches/ migraines?	YES	NO
EYE		
Have you had an eye exam in the past year? **Date:**	YES	NO
Do you suffer from blurred vision, double vision, tunnel vision, and or any abnormal sight? **Circle** any that apply	YES	NO
Do you wear contacts and/or glasses? **Circle** any that apply	YES	NO
HEAT RELATED PROBLEMS		
Have you ever suffered from a heat related injury? Circle all that apply Heat cramps Heat svncooe (faintino) Heat exhaustion Heat stroke	YES	NO
FEMALES ONLY		
At what age was your first period? _____		
Do you have heavy or painful menstrual periods?	YES	NO
Do you take any medications for you menstrual periods?	YES	NO
Are you on any type of birth control (Pill or injection?) If so what **type:**	YES	NO
Have you had a pelvic exam in the last year? **Date**	YES	NO
MISC. QUESTIONS		
Do you have any ongoing or chronic illnesses? **List**	YES	NO
Have you ever been told by a physician to restrict your sports activity or not participate at all?	YES	NO
Are you currently under a physician's care for any medical conditions? **List:**	YES	NO
Have you ever been under or are currently under the care of a psychologist and/or psychiatrist?	YES	NO
Do you cough, wheeze, or have trouble breathing during or after exercise?	YES	NO
Have you ever had a stomach ulcer or chronic stomach pains?	YES	NO
Have you had a viral infection (i.e. mononucleosis, my ocarditis, etc) in the past year?	YES	NO
Have you ever had convulsions, seizures, and/or epilepsy?	YES	NO
Do you require any special equipment? (braces, neck rolls, dental, ortholics, hearing aids etc.)	YES	NO
Have you ever had a tetanus booster within the past (5) five years? **When?**	YES	NO
Do you feel stressed out? If yes, do you feel as though you have the necessary support to deal with your stress?	YES	NO
Are you currently taking any prescription medications? **List:**	YES	NO
NUTRITION		
Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?	YES	NO
Do you regularly lose weight to participate in your sport?	YES	NO
Do you want to weigh more or less that you currently do?	YES	NO
Have you ever felt forced to limit your food intake due to concerns about your weight and/or body **size?**	YES	NO
Have you had a history of anorexia? Bulimia? (forced vomiting) and/or any other eating disorders?	YES	NO
Do you take vitamins, amino acids, crealine, and/or any' other dietary supplements on a daily basis and/or as needed?	YES	NO

If you answered, "yes" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail on following page.

I, the undersigned, hereby acknowledge, affirm, and represent that all of the above statements are 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 understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student Athlete Signature _____ **Date:** _____

PLEASE EXPLAIN ALL OF YOUR YES ANSWERS IN DETAIL BELOW

CARDIOVASCULAR RISK FACTORS:
ALLERGIES:
ASTHMA:
HEAD INJURIES/ CONCUSSIONS:
EYE:
HEAT RELATED PROBLEMS:
FEMALES ONLY:
MISC. QUESTIONS:
NUTRITION:

Gulf Coast State College Athletic
Physical Form
To Be Completed by Physician

Name _____ Date of birth _____ Sports _____

Examination			
Height	Weight	___Male ___ Female	Wingspan
BP	Pulse	Vison R 20/ L 20/	Corrected? ___ Yes ___ No

Medical	Normal	Abnormal
Appearance		
eyes/ears/nose/		
throat Lymph		
Nodes Heart		
Pulses		
Lungs		
Abdomen		
Skin		
Neurological		
Musculoskelijal	None	Present
-Marfan Characteristics (kyphoscolioisis, high-arched palate, Pectus excavatum, Arachnodactyly, arm span>Height, Mypoia, MVP, Aortic insufficiency)		
Neck		
Back		
Shoulder/Arm		
Elbow/forearm		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional-duck-walk, single leg hop		

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports with recommendations for further evaluation or treatment for _____
  _____
- ☐ Not cleared
  - ☐Pending further evaluation for _____
  - ☐For any sports
  - ☐For certain sports _____ _____Reason _____

I have examined the above-named student and completed the pre-participation physical examination and reviewed their history. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above.

Name of Physician (print)_____ Date of exam_____
Address_____ Phone_____
Signature of Physician _____ Date_____