Welcome to Labette Community College Athletics. Please review all of the forms that need to be completed before the school year begins. Each form contains information important to the student-athlete. The following forms must be completed in their entirety prior to participation in Cardinal Athletics. Please complete the required information, sign and date each form (please be sure to check the back side of all forms as some will need completed and/or signed and dated), and return them to the LCC Athletic Department Secretary. **STUDENT-ATHLETES WILL NOT BE ALLOWED TO PRACTICE OR COMPETE UNTIL ALL INFORMATION IS COMPLETE AND SUBMITTED TO THE ATHLETIC DEPARTMENT SECRETARY.**

All student-athletes must have the following forms completed and/or signed:

- **Student/Parent Information Form** (front of blue form)
- **Affidavit of No Insurance** (back of blue form) *Please sign the Affidavit of No Insurance ONLY if you do not have health insurance.*
- **Photocopy of front/back of Student-Athlete’s Health Insurance Card** (if applicable)
- **Student-Athlete Authorization/Consent for Disclosure of Protected Health Information** (tan form-1pg)
- **Sports Participation Agreement and Release** (white form-2pgs front & back)
- **Drug Testing Consent – Urine, Oral Fluid and Screen Analysis Informed Consent and Release from Liability** (green form-1pg)
- **Medical History Form** (white form-3pgs front & back)
- **Pre-Participation Physical Examination** *(Please note physicals MUST be completed and signed by a physician.)* (white form-2pgs front & back)
- **NJCAA Eligibility Affidavit** (orange form-1pg front & back)
- **Media Guide Information** (ivory form-1pg front)
- **Student Travel Agreement** (white form-1pg)

A physical examination (general medical screening) will be performed by the LCC team physicians and athletic training staff at a scheduled time during the first week of classes AT NO COST to you. (NOTE: Your coach may request a physical be completed prior to arriving on campus). Any costs incurred for physicals performed at a later time will NOT be covered by LCC. If you arrive with a physical, it must be signed by a Medical Doctor (MD) or Doctor of Osteopathy (DO). All physicals and forms must be reviewed by the LCC team physician and athletic trainer prior to clearance for participation.

A Parent/Guardian signature is required only when the student-athlete is a minor.

Mail all forms to: LCC Athletic Secretary/Margaret Doherty
200 S. 14th St.
Parsons, KS 67357

Thank you for your cooperation.
LABETTE COMMUNITY COLLEGE
STUDENT/PARENT(S)/GUARDIAN INFORMATION FORM

NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown). FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS.

I. Name of Athlete: ____________________________ Sport: ____________________________
   Social Security No. or Passport No.: ____________________________ Date of Birth: __/__/____
   Address while attending LCC: ____________________________ Cell Phone: ____________________________
   Home Address: ____________________________ Home Phone: ____________________________

II. Father/Guardian: ____________________________ Mother/Guardian: ____________________________
   Social Security No.: ____________________________ Social Security No.2: ____________________________
   Date of birth: __/__/____ Date of birth: __/__/____
   Address: ____________________________ Address: ____________________________
   Employer: ____________________________ Employer: ____________________________
   Address: ____________________________ Address: ____________________________
   Telephone (work): ____________________________ Telephone (work): ____________________________

III. Medical Insurance
   Company or Plan: ____________________________ Medical Insurance
   Company or Plan: ____________________________
   Address: ____________________________ Address: ____________________________
   Policy Number: ____________________________ Policy Number: ____________________________
   Phone Number: ____________________________ Phone Number: ____________________________

PLEASE ATTACH A PHOTOCOPY (FRONT AND BACK) OF YOUR INSURANCE CARD WITH THIS FORM. IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE SEE BACK SIDE OF THIS FORM.

Is the plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider?  ☐ Yes  ☐ No
Is pre-authorization required to obtain treatment?  ☐ Yes  ☐ No
Does your insurance or plan require a second opinion before surgery?  ☐ Yes  ☐ No

IV. Emergency contact names and phone numbers:
   __________________________________________

Other information you feel would be beneficial in an emergency situation:
   __________________________________________

V. I/we hereby authorize Labette Community College Insurance to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

I/we authorize that the college or its insurance agency to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the college.

In case of emergency, I give my permission for the Labette Community College trip sponsor to release information and to approve necessary medical treatment after attempting to contact my parent(s)/guardian or other listed contact person.

BOTH SIGNATURES ARE REQUIRED

Student Signature: ____________________________ Date: ____________________________

Parent(s)/Guardian Signature: ____________________________ Date: ____________________________

PLEASE COMPLETE REVERSE SIDE OF THIS FORM (IF APPLICABLE)
I, __________________________, **do not have insurance** or any type of accident
and health plan or service plan under which I am covered. I agree that, should it be
determined at a later date that I have collectable coverage, I will reimburse the insurance
company which handles coverage for Labette Community College to the extent of any
collectable amount. I understand that Labette Community College’s secondary coverage
will take effect provided I and/or my parent/guardian have supplied the needed verification
of no insurance coverage.

Signature of Student: __________________________ Date: __ / __ / __

Signature of Parent/Guardian: __________________________ Date: __ / __ / __

(Signature Required If Student-Athlete Under 18)
Please attach a copy of your Health Insurance Card below or on a separate page

Front of Health Insurance Card

Back of Health Insurance Card
LABETTE COMMUNITY COLLEGE

Student-Athlete Authorization/Consent
for Disclosure of Protected Health Information

I hereby authorize the LCC team physicians, LCC athletic trainer, LCC staff working with insurance companies, and other health care professionals representing Labette Community College to release information regarding my protected health information (PHI) and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, insurance carriers, and athletic and/or college administrators.

I hereby authorize the LCC Head Coach of my sport/s to release my name, body part injured or general illness information, and the date of my possible return to activity to the news media.

I understand that my authorization/consent for the disclosure of my PHI is a condition for participation as an intercollegiate athlete for Labette Community College. I understand that my PHI is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent for disclosure of protected health information at any time by notifying in writing Labette Community College, but if I do, it will not have any effect on actions Labette Community College took in reliance on this authorization/consent prior to receiving the revocation.

The duration of my permission to share personal medical information will extend from July 1st of my first year as an athlete at LCC until June 30th of my second year as an athlete. An additional year of permission may be granted in such case that I receive a medical hardship or extension of my eligibility to play intercollegiate sports due to non-participation. An extra year of permission will extend until July 30th of my third year as an athlete at LCC.

______________________________  ________________________________  _______________________
Student Athlete Signature              Student Athlete Print Name              Date

______________________________  ________________________________  _______________________
Parent/Guardian Signature              Parent/Guardian Print Name              Date
(If Athlete under 18)
I, ____________________________ desire to participate in intercollegiate sports (hereinafter referred to as "college sports") at Labette Community College. College sports include participation in practices and competition. In consideration of being allowed to participate in college sports, I hereby acknowledge and agree as follows:

I. ASSUMPTION OF RISK

There are many special benefits from the activities being offered to student athletes by the intercollegiate athletic program at Labette Community College. Within the activities it must be understood that there are dangers that may lead to injury to student-athletes. Therefore, the purpose of this section is to make all student-athletes aware that dangers do exist and that participation is voluntary with the understanding that risks are involved. It is to be further understood that student-athletes must share in the responsibility for their own safety and safety of others as each participates in college sports.

The student-athlete participating in college sports could mildly, moderately or severely injure the anatomy in one or several of the following which may include, but are not limited to: ankles, knees, shoulders, fingers, face, head, back, neck, eyes, muscles, tendons, ligaments, skin, teeth, bone, including broken bones and any of the vital organs. Catastrophic injuries of death and permanent paralysis may also occur during sports participation. There is not an absolute preventative against any of the mentioned potential injury sites.

II. ACKNOWLEDGMENT OF RISK

I acknowledge that I have read the assumption of risk statement and I am aware that there is a possibility that I may suffer mild, moderate, or severe injury, including paralysis or death, or head injury, concussion due to participation in college sports. I further acknowledge any injury incurred may cause life-long disability to joints, muscles, ligaments, tendons, or any of the vital organs.

I am in good physical and mental health and do not have any physical or mental conditions which could affect my ability to participate in college sports. I acknowledge the possibility that I may have a medical condition of which I am unaware that could put me at risk for injury or death. I fully assume all risks of injury or death in that regard as well.

III. INDEMNIFICATION AND HOLD HARMLESS

I shall indemnify and hold harmless Labette Community College including, but not limited to, its governing board and board members, its officers, employees, representatives, directors, agents, and students acting as employees for and from any and all demands, claims, actions, suits, damages, losses, liabilities, costs and expenses arising, directly or indirectly, as a result of my intentional or negligent acts, including my failure to wear protective headgear and equipment and to train properly for the sport, or omissions during or as part of college sports.

IV. COMPLIANCE WITH LAWS AND COLLEGE POLICIES

I shall fully comply with all applicable laws, Labette Community College policies, and all sports rules and regulations while in involved in college sports. If my participation in college sports is at any time deemed detrimental to the team, to Labette Community College, or to any other participants, as determined by Labette Community College in its sole discretion, I understand that I may be suspended or removed from college sports without Labette Community College incurring any liability; I also may be subject to further disciplinary action.

V. INSURANCE

Labette Community College does not provide health insurance to participants in college sports, however, athletes injured while participating in a Labette Community College sponsored activity (practice or game for Labette Community College) are covered under the Labette Community College athletic insurance policy. In order to receive
these insurance benefits athletes must complete the following steps to insure Labette Community College will cover the expenses incurred from that injury.

1. **Proof of Insurance**: I agree that prior to participating in college sports I will produce proof satisfactory to Labette Community College that I have insurance coverage. If no such coverage exists an **Affidavit of No Insurance** form will be signed, and I further agree that Labette Community College may at any time ask me to provide such proof.

2. **Injury Claim Form --- REQUIRED!**: I agree to immediately notify my Head Coach and Athletic Trainer of any injury I sustain participating in college sports while attending Labette Community College. I understand an injury claim form MUST be filled out within 30 days of the injury (including emergencies) and signed by a Labette Community College employee verifying the injury in order for any medical bills to be paid by Labette Community College athletic insurance. I understand that all appointments must go through the Athletic Trainer and any appointments made outside the advice of the Athletic Trainer will be my responsibility.

3. **Pre-Approval**: I understand that I will not be covered by Labette Community College athletic insurance if I choose to obtain non-emergency treatment outside of Labette Community College pre-authorized team physicians without prior approval from Labette Community College insurance officials and/or insurance company. I further understand that I will become responsible for any medical expenses should I obtain medical care outside the LCC network area. **Example**: Electing to utilize a physician’s group or surgical center outside the LCC network area to obtain treatment and/or second opinions on treatment options.

4. **Post-Pone Treatment of an Injury**: I understand that if I choose to post-pone treatment against the advice of Labette Community College employee(s) in order to get treatment at a later date that I may lose my ability to make a claim against Labette Community College insurance benefits.

5. **Athletes with PPO or HMO Coverage -- BE CAREFUL**: I agree to abide by all rules of MY insurance company and understand these rules must be followed first before Labette Community College’s insurance company can act on any injury claim. I understand that if I do not follow personal insurance instructions (HMO, PPO) for medical care that I may be at risk to lose benefits. **Example**: If your insurance does not pay because you did not get pre-authorization, Labette Community College’s athletic insurance will not cover the injury.

6. **Paperwork -- MUST come through LCC Athletic Office**: I understand that Labette Community College’s insurance is considered secondary insurance and benefits will begin after all bills have been processed by my (or my parent’s) primary insurance company. I agree to notify and provide the LCC athletic office with any remaining medical bills and EOBs (Explanations of Benefits) from my (or my parent’s) primary insurance company after they have been processed. I understand that failure to turn the needed paperwork in will delay or may cause non-payment of bills due to time limitations on the policy.

7. **Voluntary Workouts and/or Open Gym**: I understand that any voluntary workouts, including voluntary practices not called by the coach, and/or open gym situations where a coach is not directly observing, are done completely on my own accord. In addition, I understand that any injury occurring that requires medical referral (hospital, doctor visit, etc.) will be my financial responsibility.

8. **Labette Community College Insurance DOES NOT COVER**:
   a. Pre-existing and/or out-of-season injuries/ailments.
      *(EXCEPTION: Coverage is provided for out-of-season injuries only if athlete is being supervised by or is under the direct orders of their Head Coach.)*
   b. Illness not directly related to “approved competition” or “practice”.
      *(EXAMPLE: Colds; Ulcers; Measles; Strep Throat; Tonsillitis.)*
   c. Injuries that fall outside the insurance company’s time line.
   d. Braces for prevention of injuries **are not covered**. *(NOTE: Braces for rehabilitation purposes are covered.)*
**I UNDERSTAND THE ABOVE:** I understand that before I am approved for participation, I am required to sign below acknowledging that I have read and fully understand this agreement. I certify that I am at least eighteen years of age, fully competent, and entering into this agreement voluntarily and of my own judgment. If I am under eighteen years of age, then my parents and/or legal guardian sign below in addition to me, and in doing so, the parents/legal guardian agree to be bound by the terms hereof and agree that to the extent allowed by law this agreement shall be binding upon them and upon the student.

I understand that all other insurance rules still apply and failure to follow any of the above stated rules may result in some or possibly all my medical bills not being paid by Labette Community College.

<table>
<thead>
<tr>
<th>Print Student-Athlete Name</th>
<th>Date</th>
<th>Sport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student-Athlete Signature</td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

Signature of Parent or Legal Guardian  
(If student-athlete is under 18 years of age)
Labette Community College Athletic Association
Urine, Oral Fluid and Screen Analysis
Informed Consent and Release from Liability

In accordance with the applicable provisions of the Privacy Act of 1974.

I, _______________________________ (print full name and sport) agree to submit a sample of my urine and/or oral fluid for screening and analysis. I understand that this screen and analysis will be conducted by qualified laboratory personnel at an approved laboratory selected by the Athletic Director and team physician.

The purpose of this screen and analysis is to determine or rule out the presence of non-prescribed or prohibited, dangerous controlled substance in my urine and/or oral fluid.

Due to the provision outlined, I consent to this request for a urine and/or oral fluid specimen. I hereby and herewith release the Labette Community College Athletic Department, Labette Community College, the approved laboratory, and all employees and agents of these institutions from any liability whatsoever arising from the request to furnish this urine and/or oral sample, the testing of the urine and/or oral sample and decisions made based on the results of the analysis.

I have read the Labette Community College Drug Policy and understand its purpose, populations, methodology, drugs of consideration, drug screening conditions, and actions or sanctions. I understand a documented chain of specimen custody exists to ensure the identity and integrity of my sample throughout the collection and testing process. I further understand that my results will remain in exclusive confidential possession of the Labette Community College Athletic Department.

**Additional Conditions of Participation and Financial Aid Agreement**

I understand Labette Community College has a drug screening policy for the purpose of education, prevention, detection and deterrence of substance usage and abuse. In accepting this privilege to participate, I agree to drug screening and testing and understand that non-compliance with the policy will be a breach of this privilege to participate agreement, which may result in my removal from the team and loss of my athletic related financial aid.

______________________________
Student Athlete

______________________________
Witness

______________________________
Date

______________________________
Witness

2017-2018
Labette Community College Medical Health History Form

Name: ___________________________  Sport: ___________________________  Todays Date: ________

Date of Birth: ____________________  Sex: M   F  Athletic Eligibility: Fr   So

Home Address: ________________________________

Home Telephone #: ___________________________  Student-Athlete Cell Phone #: ___________________________

Emergency Contact Information:

Name/s: ___________________________  Relationship: ___________________________

Telephone #’s: ___________________________

Please read the following questions and answer as completely as you can.  
Fully explain all “yes” responses. If you need additional room, please attach additional sheets.

Family Health History

Are any of the following conditions present in any full blood relative? (i.e.: mom, dad, sister, brother, grandparent, etc.)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrhythmias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Disease (Sickle Cell, Leukemia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease (Before Age 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemophilia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertrophic Cardiomyopathy (HCM)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Long or Short QT Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Trait/Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden Death (Before Age 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please write their relation to you: ____________________________________________________________

Medical and Orthopedic History

Please answer the following questions about the student-athlete’s medical and orthopedic history.

Allergy History

1. Do you have an allergy to any medications? (i.e.: sulfa, aspirin, penicillin, etc.)  
   If yes, what medications?  ____________________________________________________________  Yes   No

2. Do you have any allergies to food? (i.e.: nuts, shellfish, etc.)  
   If yes, what foods?  ____________________________________________________________  Yes   No

3. Do you have an allergy to insect bites/stings?  
   If yes, what insects?  ____________________________________________________________  Yes   No

4. Do you have seasonal allergies that require medical treatment or medication?  
   ____________________________________________________________  Yes   No

5. Are you allergic to anything not mentioned above? (i.e.: latex, adhesive tape, etc.)  
   If yes, what?  ____________________________________________________________  Yes   No

6. Does a Doctor or allergy require you to carry an epi-pen?  
   ____________________________________________________________  Yes   No

LCC Medical Health History Form 1 of 5
## Do you have or have you ever had?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Clots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in Urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer or Malignancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Defect/Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease/Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis/Jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High/Low Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease/Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Stones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine Headaches</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mononucleosis (&quot;mono&quot;)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mumps</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Muscular Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Organ Not Functional/Missing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Organ Surgery</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pleurisy</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Red Measles</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Respiratory Infection</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Rubella</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Skin Condition</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Spleen Condition</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Staphylococcus/MRSA</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stomach Ulcer (Peptic)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stroke</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Thyroid Disorder</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tumor, Growth, Cyst</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Please explain all “yes” responses and list dates:

---

## Heat Illness/Nerve/Cardiac

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever had heat exhaustion, heat stroke, or “sunstroke”?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you had a pinched nerve, disk injury, or a burner/stinger?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Have you ever been unable to move your arms or legs after being hit or falling?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Have you ever felt dizzy, light-headed, or passed out during or after exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, or pressure in your chest while exercising?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Have you ever been seen by a Doctor for a heart related condition?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, when and for what?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If you have answered yes to any of these questions, please explain below and list dates:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Athletic Injuries

1. Have you ever had an injury to one of the follow body parts that caused you to miss a week or more participation in your sport?

<table>
<thead>
<tr>
<th>Skull</th>
<th>Neck</th>
<th>Eyes</th>
<th>Ears</th>
<th>Nose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throat</td>
<td>Mouth</td>
<td>Teeth</td>
<td>Abdomen</td>
<td>Ribs</td>
</tr>
<tr>
<td>Chest</td>
<td>Back</td>
<td>Spine</td>
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<td>Groin</td>
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<td>Elbow</td>
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<td>Fingers</td>
<td>Knee</td>
<td>Lower Leg</td>
<td>Ankle</td>
</tr>
<tr>
<td>Foot</td>
<td>Toes</td>
<td>Other:</td>
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<td></td>
</tr>
</tbody>
</table>

2. Have you seen a Doctor or been hospitalized for the above circled body part/s?  
3. Have you ever had a fracture, dislocation, or surgery on the above circled body part/s?  
4. Have you gone to rehabilitation/physical therapy for the above circled body part/s?  
5. Have you ever been advised to have a surgery not yet performed?  
6. If you have answered yes to any of these questions, please explain in full detail below:  
   Right or Left? Date of Injury?

# Current Medication/s

1. Are you currently taking any prescription medications?  
   (This includes all pills, inhalers, injections, ointments etc. that a Doctor prescribes.)  
   Yes No

   If yes, please list the name, dosage, and reason:

   __________________________________________
   __________________________________________
   __________________________________________

2. Are you currently taking any over-the-counter medications?  
   [i.e.: supplements, vitamins, anti-inflammatories, pain medication, or any other medications (pills, inhalers, injections, ointments etc.) not listed above]  
   Yes No

   If yes, please list the name, dosage, and reason:

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
### Concussion History

1. Have you ever had a concussion?
   - If yes, how many?
   - Who diagnosed the concussion?
   - Date of the last concussion:
   - Date of the other concussions:
   - How long did it take for complete recovery (no symptoms)?

2. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?

3. Have you ever lost consciousness/knocked out due to a blow to the head?
   - If yes, when?

4. Have you ever been hospitalized due to a head injury?
   - If yes, when?

### Miscellaneous

1. Has a Doctor ever denied or restricted your participation in sports for any reason?

2. Do you use any special equipment (pads, braces, mouth guard, etc.)?

3. Do you use an assistive or corrective device for vision or hearing during practices/games (i.e.: contact lenses, glasses, hearing aids, etc.)?

4. Do you have any ongoing medical conditions?

5. Do you currently have an injury that is not completely healed?

6. Is there any reason you are not able to participate in athletics?

7. Have you had any other medical, health, orthopedic, surgery, injury, or comments/concerns/problems that have not been mentioned on this form?

8. Are there any additional health problems/concerns that you would like to discuss privately with the athletic trainer and/or team Doctor?

9. If you have answered yes to any of these questions, please explain below and list dates:

---

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

Printed Name of Athlete: ________________________________

Signature: ________________________________ Date: __________

**Parent/Guardian Signature (only if under 18 years old): ________________________________ Date: __________
Concussion Acknowledgement

What is a concussion?

- **A brain injury that is caused by a blow to the head or body**
  - Causes can include hitting a hard surface such as the ground/floor, contact with another player, or being hit by a piece of equipment such as a ball
- It can range from mild to severe
- It can occur during practice or competition in ANY sport
- It is different for each athlete
- **It can happen even if you do NOT lose consciousness/get knocked out**

What are the symptoms of a concussion?

- Balance Problems
- Blurred Vision
- Difficulty Concentrating
- Headaches
- Irritability
- Nausea/Vomiting
- Nervous or Anxious
- Ringing in the Ears
- Sadness
- Sensitivity to Light
- Sensitivity to Noise
- Slowed Reaction Time

What should I do if I think I have a concussion?

**Don’t hide it.** Tell your athletic trainer if you or your teammate might have a concussion. Never ignore a blow to the head. Sports have injury timeouts and player substitutions so that you can get checked out.

**Report it.** Do not return to participation in a game, practice, or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

**Get checked out.** Your athletic trainer or Team Doctor can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep, and classroom performance.

**Take time to recover.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage and even death. Severe brain injury can change your whole life.

**It’s better to miss one game than the whole season.**

When in doubt, get checked out.

Information From: NCAA Concussion Fact Sheet, Centers for Disease Control and Prevention, and the Kansas Sports Concussion Partnership

By signing the below, I state that I have read and understand the presented information, including signs and symptoms. I also confirm that I shall always report any suspecting concussions (of myself or others) to the Labette Community College athletic training staff.

Printed Name of Student - Athlete: ___________________________ Date: __________

Signature: ______________________________________________________ Date: __________

**Parent/Guardian Signature (only if under 18 years old): __________________ Date: _________**
# Labette Community College
## Pre-Participation Physical Examination

### HISTORY

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<table>
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<table>
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<th>In case of emergency, contact</th>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone(H)</th>
<th>(W)</th>
</tr>
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Explain “Yes” answers below.

**Circle questions you don’t know the answer to.**

1. Have you had a medical illness or injury since your last check up or sports physical?
   - Do you have an ongoing or chronic illness?

2. Have you ever been hospitalized overnight?
   - Have you ever had surgery?

3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?
   - Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?

4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?
   - Have you ever had rash or hives develop during or after exercise?

5. Have you ever passed out during or after exercise?
   - Have you ever been dizzy during or after exercise?
   - Have you ever had chest pain during or after exercise?
   - Do you get tired more quickly than your friends do during exercise?
   - Have you ever had racing of your heart or skipped heartbeats?
   - Have you had high blood pressure or high cholesterol?
   - Have you ever been told you have a heart murmur?
   - Has any family member or relative died of heart problems or of sudden death before the age of 50?
   - Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?
   - Has a physician ever denied or restricted your participation in sports for any heart problems?

6. Do you have any current skin problems, (for example, itching,
rashes, acne, warts, fungus, or blisters)?
7. Have you ever had a head injury or concussion?
   Have you ever been knocked out, become unconscious, or lost your memory?
   Have you ever had a seizure?
   Do you have frequent or severe headaches?
   Have you ever had numbness or tingling in your arms, hands, legs, or feet?
   Have you ever had a stinger, burner, or pinched nerve?
8. Have you ever become ill from exercising in the heat?
9. Do you cough, wheeze, or have trouble breathing during or after exercise?
   Do you have asthma?
   Do you have seasonal allergies that require medical treatment?
10. Do you use any special protective or corrective equipment or devices that
    are not usually used for your sport or position (for example, knee brace, special
    neck roll, foot orthotics, retainer on your teeth, hearing aid?)
11. Have you had any problems with your eyes or vision?
    Do you wear glasses, contacts, or protective eyewear?
12. Have you ever had a sprain, strain, or swelling after injury?
    Have you broken or fractured any bones or dislocated any joints?
    Have you had any other problems with pain or swelling in
    muscles, tendons, bones, or joints?
If YES, check appropriate box and explain below.
   □ Head □ Elbow □ Hip □ Neck □ Forearm □ Upper arm
   □ Thigh □ Back □ Wrist □ Knee □ Chest □ Foot
   □ Hand □ Shin/calf □ Shoulder □ Finger □ Ankle
13. Do you want to weigh more or less than you do right now?
    Do you lose weight regularly to meet weight?
    Requirements for sport?
14. Do you feel stressed out?
15. Record the dates of your most recent immunizations (shots) for:
   Tetanus □ Measles □ Hepatitis B □ Chickenpox
   □
   □
   □
   □
FEMALES ONLY
16. When was your first menstrual period?
    When was your most recent menstrual period?
    How much time between the start of one period to the start of another?
    What was the longest time between periods in the last year?
    Explain all “Yes” answers here:
   ————
I hereby state that, to the best of my knowledge, my answers to the above questions are complete
and correct.
Signature of athlete __________________________ Signature of parent/guardian ___________________
**PHYSICAL EXAMINATION**

Name __________________________ Date of birth __________________________

Height ___  Weight ___  % Body fat ___  Pulse ___  BP (___/___, ___/___)

Vision  R 20/___  L 20/___  Corrected: Y  N  Pupils: Equal ___  Unequal ___

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<tr>
<td>Foot</td>
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</tbody>
</table>

**CLEARANCE**

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:

☐ Not cleared for: __________________________  Reason: __________________________

Recommendations: __________________________

Name of physician (print/type) __________________________  Date ______

Address __________________________

Signature of physician __________________________, MD or DO
NJCAA Eligibility Affidavit

SPORT: ___________________________ Date: ______________

Fill in all applicable information on this form to assist in determining eligibility for the NJCAA.

Personal Information:
Name: ___________________________ Birth Date: __/__/____ ID Number: __________________
(First, Middle, Last)

Student's College Address:
Street Address ___________________________ City, State, Zip Code _______________

Phone Number(s) at College: ___________________________ Email Address: _______________

Other Information:
Parent's Home Address:
Street Address ___________________________ City, State, Zip Code _______________

Phone Number: ___________________________ Parents' Names: ___________________________

Foreign Born Students:
Do you have an I-20 Form on file at this college? Yes _____ No _____

High School Information:
Name of High School(s) you have attended: ___________________________

City, State & Country: ___________________________

Did you graduate? Yes* _____ No _____ High School Graduation Date (month/date/year): __/__/____

Were you home schooled? Yes _____ No _____ Did you graduate? Yes* _____ No _____

Check here if you have earned a *GED or state department of education approved high school equivalency test
Yes_____ No_____ If yes, enter the date earned (month/date/year): __/__/____

* Enclose a COPY of your High School Transcript, and GED Certificate or state department of education approved
high school equivalency test (if applicable).

Additional Information:
1. Did you take any college credit classes while in high school? Yes* _____ No _____
   * If yes, from what college(s)? ___________________________
   * If yes, those transcript(s) from each college must be on file at this college.

2. Have you ever signed a Letter of Intent form with any institution? Yes ____ No _____
   If yes, specify the College: ___________________________ Date (day/month/year): __/__/____

3. Have you ever participated in a sport in a country other than the United States? Yes _____ No _____
   Sport(s): ___________________________ Country: ___________________________ Dates: __________________
   If yes, describe the situation: ___________________________

4. Have you ever been red-shirted for a season? Yes _____ No _____
   If yes, list the dates of that season, name of college, and describe the situation: ___________________________

(PAGE 2 - NJCAA ELIGIBILITY AFFIDAVIT CONTINUED)
5. Have you ever participated in practices, scrimmages, and/or games for an intercollegiate team other than this college? Yes _____ No _____ If yes, name the school, date, sport, and describe the situation.

6. Have you ever played on a club team at a college or university? Yes _____ No _____ If yes, name the school, sport and dates.

7. Do you currently play on any other sport teams (i.e. USAV, city recreational leagues, indoor soccer, AAU, etc.) Yes _____ No _____ If yes, please provide the name of team, location, and dates of participation.

8. Have you ever received money beyond expenses for participating in any athletic event? Yes _____ No _____ Did anyone on your team receive money beyond expenses for participating in any athletic event? Yes _____ No _____ If yes, describe the situation below and the NJCAA Amateurism Questionnaire should be completed and included with the eligibility file.

---

List ALL Colleges Attended Full-Time and/or Part-Time after High School
All transcripts from all previous institutions must be included.

College: ___________________________ Dates: ___________________________ Full-time or Part-time? (circle one)

College: ___________________________ Dates: ___________________________ Full-time or Part-time? (circle one)

College: ___________________________ Dates: ___________________________ Full-time or Part-time? (circle one)

College: ___________________________ Dates: ___________________________ Full-time or Part-time? (circle one)

Additional Explanations:
NOTE: If you attended college part-time or were not attending college for any period of time following high school graduation, please document your employment and military history during those times in the space below. If you were unemployed at any time, please list those dates below. The NJCAA requires that you account for any time not enrolled full-time. Please use the space below. Please record months and years when referring to dates.

---

I understand that information falsified or omitted can make me ineligible for ALL future college competition in compliance with the National Junior College Athletic Association Eligibility Rules.

Student-Athlete Signature: ___________________________ Date: ___________________________

Coach Signature: ___________________________ Date: ___________________________
Media Guide Information

First, Middle, Last Name: ________________________________

Sport: ________________________________

Position: ________________________________

Hometown: ________________________________

High School: ________________________________

Birthday: ________________________________

Height: ________________________________

Class (Fr. or Soph.): ________________________________

Expected Major: ________________________________

Parent’s Names (Please list as you want listed in the Media Guide):

______________________________

______________________________

Sibling’s Names: ________________________________

Other Sports: ________________________________

Clubs: ________________________________

H.S. Honors (Sports and Other):

______________________________

______________________________

______________________________

______________________________

______________________________
Labette Community College

Student Travel Agreement

I, ________________________________, do willfully accept the opportunity to travel as a part of a Labette Community College Course/Program/Activity. I understand that I am participating in certain risk and danger, including but not limited to, accidents, illness, and forces of nature and travel.

In exchange for this opportunity provided to me, I hereby state that I will not take any action, legal or otherwise, against Labette Community College and any person acting by or through Labette Community College. I will hold Labette Community College and persons acting on their behalf harmless from any and all liability, loss, damage, or injury that I may experience as a result of this opportunity. The terms hereof shall serve as a release of my assuming any and all risks of harm for my heirs, executors, and administrators, and for all members of my family, including any minors.

In addition, I understand that I must adhere to the Labette Community College Code of Student Conduct that is published in the Labette Community College Catalog. This includes but is not limited to:

1. Using foul language.
2. Misconduct, including disrespect for and disturbing others.
3. Physical or verbal abuse or the mistreatment of any person.
4. Theft, vandalism, defacement, or damage to property of others.
5. Disorderly conduct.
6. Drinking alcohol or using any illegal substances.
7. The use of tobacco products and/or smoking in nonsmoking areas.
8. Violation of any criminal law or community college policy.

FAILURE TO ADHERE TO THE STUDENT CODE OF CONDUCT WILL RESULT IN THE DISCIPLINARY ACTIONS SET FORTH BY LABETTE COMMUNITY COLLEGE UPON RETURN UP TO AND INCLUDING SUSPENSION AND EXPULSION.

______________________________  __________________________
Signature of Applicant                        Date

______________________________  __________________________
Signature of Parent if applicant is under 18                        Date

PLEASE NOTE: When participating in travel with Labette Community College, the student must present this form to the trip sponsor. The original needs to be turned in to the Vice-President of Student Affairs Office. A copy should be made for the sponsor and the student. If information recorded on the form changes, a new Student Travel Agreement should be completed.