



## Howard Community College Athletics Medical Information and Physical Forms

Dear Student-Athlete:

Welcome to Howard Community College Athletics! As an athlete at HCC, have access to athletic training services provided by Union Memorial Sport Medicine. The athletic trainer (AT) is contracted for 37.5 hours, which covers all home contests and most practices, in addition to injury evaluation and injury rehab time. The AT is located between the locker rooms in AF 132.

**It is required** that you have a pre-participation physical exam **prior** to beginning practice with your team. The HCC athletic department hosts physical exams by physicians from Union Memorial Hospital, during the first week in August at HCC. The cost is \$25 cash.

**You must complete the following steps prior to competing in order to be considered medically eligible to participate in HCC practices or games.**

- I. Read, sign, and date both the HCC Assumption of Risk/Liability Affidavit (Page 2) and Disclosure of Protected Health Information (Page 3).
- II. Completely fill out the Emergency Contact Form including full insurance information and emergency contact information (Page 4).
- III. Take each of these three forms: **I. General Medical History (Page 5), II. Orthopedic History (Page 6), III. Pre-Participation Physical Evaluation forms (Page 7)** to your physical examination for the physician to sign and date.
- IV. Turn in all completed info to the athletic trainer

The athletic trainer is available to assist the athletes with injury prevention, first-aid, injury assessments, injury rehabilitation and more as necessary. If you make time for the AT to help you will be back in action before you know it.

Have a successful and safe athletic season!

Tim Happel MS, ATC, NASM-PES  
Certified Athletic Trainer  
Union Memorial Sports Medicine  
Howard Community College

## Howard Community College Assumption of Risk/Liability Affidavit

1. I 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.
2. I understand that I must refrain from practices or games during medical treatment until I am discharged from treatment by a physician, or the certified athletic trainer of Howard Community College.
3. I understand and accept the risks of injury, permanent disability, and death that are inherent in participating in athletic events. By signing below, I pledge to reduce these risks by keeping in the best possible athletic condition, and to follow the advice of a physician, certified athletic trainer and/or coaching staff, concerning the prevention, treatment, and rehabilitation of athletic injuries.
4. I understand and voluntarily assume all risks inherent in the nature of this activity. I waive all claims, costs, liabilities, expenses, and judgments against HCC and Howard County government and release HCC and its trustees, officers, agents, representatives, and employees and Howard County government from all claims, costs, liabilities, expenses, and judgments arising out of my participation in the activity.

### Insurance and Treatment Consent

5. I grant permission to the sports medicine staff of Howard Community College to hospitalize and secure treatment for myself for any athletic injuries. If the athlete is a minor, the undersigned parent/guardian grants permission to the sports medicine staff to hospitalize and secure treatment for my son/daughter.
6. I understand that Howard Community College maintains secondary insurance coverage for student-athletes and associated athletic professionals. However, the policy is a secondary medical plan and will only compensate for medical expenses after the student-athlete's primary insurance has been exhausted. Therefore, student-athletes are required to maintain their own health insurance in order to participate in athletics at Howard Community College. The college's secondary policy covers illnesses and/or an injury sustained during authorized athletic events and includes a \$250 deductible. Eligibility for reimbursement is determined by the insurance company in coordination with the HCC athletic department, and the Risk Management Department of Howard Community College.
7. Permission is hereby granted to the certified athletic trainer of Howard Community College and Union Memorial Sports Medicine to proceed with any medical first-aid treatment for the below named participant. In the event of a serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made to contact the parent/guardian in the most prompt manner possible. In the event that I cannot be reached, the treatment necessary for the best interest of the athlete may be given.

I, the undersigned student-athlete, have read and understood the preceding medical policy statement, agree to follow its procedures, and hereby give consent and hold harmless Howard Community College and Union Memorial Sports Medicine from liability.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Student-Athlete (please print)

\_\_\_\_\_  
Signature of Parent/Guardian (if student-athlete is under the age of 18)      Date

Howard Community College, Department of Athletics  
 Student Athlete Consent Form  
 Disclosure of Protected Health Information

I, \_\_\_\_\_, hereby authorize **Howard Community College Athletics**  
 (Name of Student Athlete)

and its physicians and athletic trainers (of Union Memorial Hospital), to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to coaches and athletic department staff.

I understand that my injury/illness information is protected by federal regulations under the Health Insurance Portability and Accountability Act of 1996, and may not be disclosed without my authorization. I also understand that I am not required to sign this consent in order to be eligible for participation in NJCAA athletics.

I have the right to revoke this consent at any time by sending written notification to the athletic director of my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this consent.

\_\_\_\_\_  
 Printed Name of Student Athlete

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Howard Community College  
Student Athlete Emergency Information Form

**Please complete both copies**

Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Print)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

**Insurance Information**

Do you have medical insurance? Yes No **If yes fill out below**

Name of Plan: \_\_\_\_\_ Policy/ID Number: \_\_\_\_\_

Group Number (if available) \_\_\_\_\_ Type of Insurance: HMO PPO POS

Who is the primary card holder: \_\_\_\_\_ Primary card holder DOB: \_\_\_\_\_

-----

Howard Community College  
Student Athlete Emergency Information Form

Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Print)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

**Insurance Information**

Do you have medical insurance? Yes No **If yes fill out below**

Name of Plan: \_\_\_\_\_ Policy/ID Number: \_\_\_\_\_

Group Number (if available) \_\_\_\_\_ Type of Insurance: HMO PPO POS

Who is the primary card holder: \_\_\_\_\_ Primary card holder DOB: \_\_\_\_\_

## Howard Community College General Medical History Physical Form

**This section to be filled out by student-athlete:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M F Sport: \_\_\_\_\_

### General Medical History

- 1) Have you ever had chest pain? Yes No Explain: \_\_\_\_\_
- 2) Have you ever had breathing problems during or after exercise? Yes No Explain: \_\_\_\_\_
- 3) Have you ever passed out during or after exercise? Yes No How often? When? \_\_\_\_\_
- 4) Do you feel like you get dizzy more than most people? Yes No
- 5) Have you been diagnosed with EIA or athsma? Yes No Explain: \_\_\_\_\_
- If yes to #12, are you medicated and/or use an inhaler\*? Yes No **\*Please provide a spare inhaler to your ATC for emergency situations\***
- 6) Have you ever had high blood pressure? Yes No Explain: \_\_\_\_\_
- 7) Does anyone in your family have history of high blood pressure? Yes No If so who: \_\_\_\_\_
- 8) Have you ever had a heart murmur or significant dysrhythmias? Yes No Explain: \_\_\_\_\_
- 9) Has a relative died of heart related sudden death before age 50? Yes No Explain: \_\_\_\_\_
- 6) Do you have any known allergies/medical conditions? Yes No Explain: \_\_\_\_\_  
(Bee sting allergy, Diabetic, Epilepsy, Sickle cell, Martfan Syndrome etc.)
- 7) Have you ever had a seizure? Yes No Explain: \_\_\_\_\_
- 8) Have you been diagnosed with ADD/ADHD? Yes No
- 9) Have you ever had heat a heat related injury? Yes No Explain: \_\_\_\_\_  
(Heat exhaustion, heat stroke)
- 10) Do you currently have any skin problems? Yes No Explain: \_\_\_\_\_  
(Itching, rashes, severe acne, etc)?
- 11) Have you ever had a stinger, burner or pinched nerve? Yes No How many: \_\_\_\_\_
- 12) Have you ever suffered a concussion? Yes No How Many? When? \_\_\_\_\_
- 13) Are you taking any supplements or other ergongenec aids? Yes No Explain: \_\_\_\_\_
- 14) Do you wear glasses, contacts or protective eyewear? Yes No Explain: \_\_\_\_\_
- 15) Do you use any special protective or corrective equipment? Yes No Explain: \_\_\_\_\_  
(i.e., knee brace, hearing aid)
- 19) Do you have a pin/plate in your body as a result of surgery? Yes No Where/When: \_\_\_\_\_
- 16) Are you happy with your weight? Yes No
- 17) Are you trying to lose weight? Yes No How Much: \_\_\_\_\_
- 18) Are you taking any supplements or other ergongenec aids? Yes No Explain: \_\_\_\_\_
- 19) Do you carefully contol what you eat? Yes No If yes how many meals/calories daily: \_\_\_\_\_
- 20) Have you ever been diagnosed with an eating disorder? Yes No What and when: \_\_\_\_\_

### Females Only

- 21) How old were you when you had your first menstual cycle? \_\_\_\_\_
- 22) How many cycles have you had in the last 12 months \_\_\_\_\_
- 23) Are you on any medication that may alter your menstrual cycle? Yes No If yes what? \_\_\_\_\_

Have you had any other medical problems in the last month (i.e. mononucleosis, Flu, hepatitis, hernea?) If yes Please explain below:

Do you have other medical problems your physician or athletic trainer or that they should be aware of? If yes, please explain below:

**I affirm that, to the best of my knowledge, the answers to the above questions are true and correct.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of parent/guardian if student-athlete is under 18 yrs.)

## Howard Community College Orthopedic History Physical Form

Have you ever had any injuries (sprains, strains, fractures, dislocations, surgeries) to the following areas?

Please include dates and name of physician who performed any procedures or surgery. If physical therapy was necessary please give dates, therapists name and organization name if possible.

Head/Neck:    Yes    No \_\_\_\_\_

Shoulder:      Yes    No \_\_\_\_\_

Elbow:         Yes    No \_\_\_\_\_

Hand & Wrist: Yes    No \_\_\_\_\_

Chest/Ribs:    Yes    No \_\_\_\_\_

Back:          Yes    No \_\_\_\_\_

Hip/Pelvis:    Yes    No \_\_\_\_\_

Thigh/Knee:    Yes    No \_\_\_\_\_

Lower Leg:     Yes    No \_\_\_\_\_

Ankle/Foot:    Yes    No \_\_\_\_\_

Do you have any pins, plates, screws, or anything metal in your body?    YES                      NO

If so, list where: \_\_\_\_\_

**I affirm that, to the best of my knowledge, the answers to the above questions are true and correct.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of parent/guardian (if student-athlete is under 18 yrs.)**

-----  
**I have reviewed the athletes general and orthopaedic medical history listed above.**

**Physician Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### Howard Community College Pre-Participation Physical Evaluation

**This section to be completed by physician:**

Sport(s) participating in: \_\_\_\_\_ Date of Exam: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_/\_\_\_ Pulse: \_\_\_\_\_

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

MEDICAL EXAM	Normal	Abnormal findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia		
Skin		
MUSCULOSKELTAL EXAM		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Significant past medical history (head injury, illnesses, surgery, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Clearance**

Cleared                       Cleared after completing evaluation/rehabilitation for:  
\_\_\_\_\_

Not cleared for Sports(s): \_\_\_\_\_  
\_\_\_\_\_

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone :(\_\_\_\_) \_\_\_\_\_

**I have noted the history of and examined this student athlete; finding him/her able to safely participate in intercollegiate athletics:**

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Pre-participation Physical Exam Locations

The following locations offer physical exams on a “no appointment necessary” basis. Please call the individual office for pricing, hours of operation, and other information. **HCC athletics is not affiliated with any of these locations. Pricing will vary by location.**

### Concentra Medical Center- Elkridge

7377 Washington Blvd Suite 101  
Elkridge, MD 21075  
(410) 379-3051

### Concentra Medical Center- Columbia

6656 Dobbin Road  
Columbia, MD 21045  
(410) 381-1330

### Patient Care MD Walk-In Clinic

9650 Santiago Rd  
Ellicott City, MD 21043  
(410) 884-1500

**Medical**

### 40 West Walk In Medical Center

8455 Baltimore National Pike  
Ellicott City, MD 21043  
(410) 465-6300

### Patient First- Laurel

3357 B Corridor Marketplace  
Laurel, MD 20724  
(301) 497-1820

**1 Birth**

oor

### Affiliated with HCC and Union Memorial Hospital (By appointment only)

#### Arnold Palmer SportsHealth Center

Johnston Professional Building  
3333 North Calvert Street, Suite 210  
Baltimore, MD 21218

**Call: 410-554-6868 prior for appointment**