



Department of Athletics  
Central Arizona College  
8470 N. Overfield Rd.  
Coolidge, AZ 85128  
Phone: (520) 494-5306  
Fax: (520) 494-5466

Dear CAC Athlete/Parent(s):

In anticipation of the upcoming athletics season this letter is to inform you and your parents of the requirements of Central Arizona College. All athletes need a pre-participation physical examination prior to the start of the athlete's season. Also required on file is information regarding insurance coverage and HIPPA regulations which you will find included in the packet.

The physical form used at Central Arizona College is a four page form. Please complete the first two pages with all the information that is requested. The athlete needs only to put his name and sport on the third and fourth pages. The last two pages are to be completed by the doctor/medical provider performing the physical exam. A medical doctor (M.D.), an osteopathic doctor (D.O.), a physician assistant (P.A.C.) or a nurse practitioner (N.P.) must sign off on the form. Physical examinations performed before June 1 will not be accepted. Please have the doctor's office stamp the form to verify it was performed by a licensed professional.

Another requirement for the student athlete is to have some type of primary health insurance coverage. The insurance coverage provided through the college is "supplemental" or "secondary" accidental insurance only, which means the primary insurance, is billed first. The secondary accidental insurance only covers injuries which would occur while the student athlete is participating in his/her sporting activity. It does not include prior injuries, diseases, or illnesses. Please complete the Athlete Accident Insurance form and the Parent Insurance form and return along with the physical.

**Please turn in the following forms to the Head Athletic Trainer (Athletes are NOT allowed to participate in sporting activity without these turned in):**

\_\_\_\_\_ **Four page physical Form (ECG Cardiovascular Screening Recommended)**

\_\_\_\_\_ **Athlete Accident Insurance Form**

\_\_\_\_\_ **Parent Insurance Form w/ copy of Insurance Card (front and back)**

\_\_\_\_\_ **HIPPA Waiver Form**

\_\_\_\_\_ **Concussion/ImPACT Form**

\_\_\_\_\_ **Return the completed and signed forms to:**

**Janie Kelly, ATC  
Head Athletic Trainer  
Central Arizona College  
8470 N. Overfield Rd.  
Coolidge, AZ 85128**

Please feel free to contact me with any questions or concerns. Thank you in advance for assisting in the process of preparing for the coming athletic season.

School Year: \_\_\_\_\_

Sport(s): \_\_\_\_\_

**CENTRAL ARIZONA COLLEGE**

Health History Questionnaire

Please complete the following form. All information is private and confidential. If you have a medical condition, a physician release may be required prior to participating in your sport.

**GENERAL INFORMATION**

\_\_\_\_\_  
LAST NAME FIRST NAME SOCIAL SECURITY #

\_\_\_\_\_  
PERMANENT ADDRESS

\_\_\_\_\_  
CITY STATE ZIP CODE

\_\_\_\_\_  
HOME PHONE # DORM PHONE # BIRTH DATE

**EMERGENCY CONTACT**

\_\_\_\_\_  
LAST NAME FIRST NAME RELATIONSHIP PHONE

**PHYSICIAN INFORMATION**

\_\_\_\_\_  
PHYSICIAN NAME PHONE

**INSURANCE INFORMATION**

\_\_\_\_\_  
INSURANCE COMPANY NAME OF POLICY HOLDER

**MEDICATIONS**

Please list all medications you are currently taking, and for what reason.

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

Please list any medications to which you are allergic:

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

## HEALTH HISTORY

### HEAD

- |   |     |    |
|---|-----|----|
| 1. Do you experience headaches?                                     | Yes | No |
| If yes, how often do they occur?                                    |     |    |
| Where are they located?   |     |    |
| Do you take any medication to relieve them?                         | Yes | No |
| If yes, what do you use?  |     |    |
| 2. Do you have any episodes of dizziness, seizures, or convulsions? | Yes | No |
| 3. Have you ever fainted  | Yes | No |
| 4. Have you ever had a head or neck injury?                         | Yes | No |
| If yes, did you lose consciousness?                                 | Yes | No |
| If yes, how long were you unconscious?                              |     |    |
| Were you under the care of a doctor?                                | Yes | No |
| Paralysis, numbness, tingling, or weakness of any extremity?        | Yes | No |
| If yes, how long before you resumed normal activity?                |     |    |

### EYES

- |  |     |    |
|--|-----|----|
| 1. Do you wear contacts or eye glasses?  | Yes | No |
| 2. Have you ever had a problem with your eyes? Circle: a) Trauma b) Loss of Vision c) Pink eye d) Pain |     |    |

### EARS

- |  |     |    |
|--|-----|----|
| 1. Have you ever had a problem with your ears?   | Yes | No |
| 2. If yes, circle: a) Infection b) Swimmer's ear c) Pain d) Drainage e) Loss of Hearing f) Other |     |    |

### NOSE

- |  |     |    |
|--|-----|----|
| 1. Have you ever had a problem with your nose?       | Yes | No |
| If yes, circle: a) Broken b) Sneezing c) Nose bleeds |     |    |

### THROAT

1. How often do you have colds or sore throats?

### SKIN

- |                                  |     |    |
|----------------------------------|-----|----|
| 1. Do you ever have a skin rash? | Yes | No |
| If yes, explain.                 |     |    |

### CHEST

- |                                     |     |    |
|-------------------------------------|-----|----|
| 1. Do you ever have chest pains?    | Yes | No |
| If yes, explain.                    |     |    |
| 2. Do you have a chronic cough?     | Yes | No |
| 3. Have you ever coughed up blood?  | Yes | No |
| 4. Do you have hay fever or asthma? | Yes | No |

### HEART

- |  |     |    |
|--|-----|----|
| 1. Have you ever been told you have a heart murmur?      | Yes | No |
| 2. Have you ever been told you have high blood pressure? | Yes | No |
| 3. Do you have a family history of heart disease?        | Yes | No |

### ABDOMINAL

- |  |     |    |
|--|-----|----|
| 1. Do you have trouble with any of the following (circle): a) Heartburn b) Indigestion c) Nausea d) Vomiting e) Constipation f) Lack of Appetite |     |    |
| 2. Have you ever passed blood in your stools?  | Yes | No |
| 3. Have you ever noted burning or urination?   | Yes | No |

### SKELETAL

- |   |     |    |
|---|-----|----|
| 1. Have you ever had arthritis?   | Yes | No |
| 2. Sprained ankle? If yes, explain.   | Yes | No |
| 3. Knee injury? If yes, explain.  | Yes | No |
| 4. Shoulder injury? If yes, explain.  | Yes | No |
| 5. Broken bone? If yes, explain.  | Yes | No |
| 6. Neck injury? If yes, explain.  | Yes | No |
| 7. Back trouble? If yes, explain.   | Yes | No |
| 8. Have you ever had a dislocation, If yes, explain.                                  | Yes | No |
| 9. Have you ever had surgery? If yes, explain.  | Yes | No |
| 10. Does any joint feel loose or painful? If yes, explain.                            | Yes | No |
| 11. Do you have a pin, plate, screw, or anything metal in your body? If yes, explain. | Yes | No |

### GENERAL

- |   |     |    |
|---|-----|----|
| 1. Do you have a drug allergy or any other allergies? | Yes | No |
| 2. Do you have diabetes?                              | Yes | No |
| 3. Do you have any sexually transmitted diseases?     | Yes | No |
| 4. Have you ever had heat stroke or heat exhaustion?  | Yes | No |
| 5. Do you have sickle cell?                           | Yes | No |

**CENTRAL ARIZONA COLLEGE  
SPORTS MEDICINE**

**PRE-PARTICIPATION PHYSICAL EXAM**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

SPORT \_\_\_\_\_ SEX \_\_\_\_\_ BP \_\_\_\_\_

HEART RATE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

VISION \_\_\_\_\_ CORRECTED \_\_\_\_\_ UNCORRECTED \_\_\_\_\_

SKIN \_\_\_\_\_ NORMAL/ABNORMAL

DENTAL/MOUTH \_\_\_\_\_ NORMAL/ABNORMAL

EARS \_\_\_\_\_ NORMAL/ABNORMAL

NOSE \_\_\_\_\_ NORMAL/ABNORMAL

THROAT \_\_\_\_\_ NORMAL/ABNORMAL

HEART \_\_\_\_\_ NORMAL/ABNORMAL

LUNGS \_\_\_\_\_ NORMAL/ABNORMAL

ABDOMEN \_\_\_\_\_ NORMAL/ABNORMAL

LYMPHATICS \_\_\_\_\_ NORMAL/ABNORMAL

VALSALVA MANEUVER \_\_\_\_\_ NORMAL/ABNORMAL

DISPOSITION      No participation  
                         Limited participation  
                         Cleared for participation

COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**CENTRAL ARIZONA COLLEGE  
SPORTS MEDICINE  
ORTHOPEDIC SCREENING**

NAME \_\_\_\_\_

SPORT \_\_\_\_\_

Check if Normal

CERVICAL SPINE:

Previous injury \_\_\_\_\_

Flexibility/ROM \_\_\_\_\_

Strength \_\_\_\_\_

Joint Stability \_\_\_\_\_

TRUNK:

Previous injury \_\_\_\_\_

Flexibility/ROM \_\_\_\_\_

Strength \_\_\_\_\_

Joint Stability \_\_\_\_\_

SHOULDER:

Previous injury \_\_\_\_\_

Flexibility/ROM \_\_\_\_\_

Strength \_\_\_\_\_

Joint Stability \_\_\_\_\_

HIP:

Previous injury \_\_\_\_\_

Flexibility/ROM \_\_\_\_\_

Strength \_\_\_\_\_

Joint Stability \_\_\_\_\_

KNEE

Previous injury \_\_\_\_\_

Flexibility/ROM \_\_\_\_\_

Strength \_\_\_\_\_

Joint Stability \_\_\_\_\_

ANKLE:

Previous injury \_\_\_\_\_

Flexibility/ROM \_\_\_\_\_

Strength \_\_\_\_\_

Joint Stability \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



Signal Peak Campus  
8470 N. Overfield Rd  
Coolidge, AZ 85128

## Athletic Accident Insurance

As an athlete at Central Arizona College you are provided with a **secondary accident insurance policy**. This insurance policy is **NOT** a health insurance policy and may not be used in cases of illness. **This is an accident insurance policy that provides supplemental (secondary) coverage for all injuries sustained while participating in intercollegiate athletics.**

This means that your personal insurance (primary insurance) carrier **WILL BE** utilized and they will pay their normal benefits before the school's supplemental accident insurance will pay any benefits. For example: if you belong to an HMO or PPO (CIGNA, Intergroup, Aetna, BC/BS, etc.), you **must** follow their procedure for filing a medical claim. After your private insurance has paid its portion of the benefits, then the secondary accident insurance will apply to the remaining portion of the medical bill. As with all insurance carriers, the supplemental accident insurance has its restrictions and exclusions. Therefore, all claims **must** be filed as soon as possible with the athletic trainer to prevent claim denial due to time restrictions. In addition, the supplemental accident insurance is **not required** to pay all remaining balances after the primary insurance carrier has been utilized. If this is the case, the remaining balance after both the primary and supplemental insurance have been utilized, **is the responsibility of the student athlete.**

The athletic trainer will assist you with filing a claim with the supplemental accident insurance carrier. It is important to note that all medical bills are the **responsibility of the student athlete. It is also the responsibility of the student athlete that all medical claims are properly filed with their own personal (primary) insurance carrier, and with the school provided supplemental accident insurance carrier.** If a medical claim is not filed properly or the primary insurance carrier's guidelines are not followed the student athlete will be responsible for any and all medical bills. The supplemental accident insurance policy requires that a Parent Insurance Form be attached when claims are sent in. **Please be sure to fill out and return to the Parent Insurance Form to the Athletic Trainer; otherwise the student athlete will not be allowed to participate in any sporting activity.** At times the supplemental accident insurance policy will require additional information from the student athlete. Again this is the sole responsibility of the student athlete to follow through with all additional requests from both the primary and supplemental insurance companies. Failure to follow through with these requests can lead to failure and delay of any payment for medical treatments and the possibility of the student athlete going into collections.

My signature verifies that I understand the accident insurance policy provided by Central Arizona College is a supplemental insurance policy. I also understand that if I do not follow the claim filing procedures set forth by my primary insurance carrier and the school provided supplemental insurance carrier, **I will be responsible for all medical bills.**

Printed name: \_\_\_\_\_

Sport: \_\_\_\_\_

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

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

Signature of Parent/Guardian if Student athlete is under 18:

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

\*\*Note: The verification of other insurance **MUST** be filled out completely, in addition to the parent/guardian's employer's address. Failure to provide this information to the supplemental accident insurance carrier may cause denial of any claims for benefits.

# Parent's Insurance Form

Athlete's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Sport: \_\_\_\_\_ School: Central Arizona College

Dear Parent:

Our athletic accident policy, which provides insurance for your son/daughter for injuries occurring while participating in the play or practice of intercollegiate sports is "SECONDARY" to any other collectible group insurance benefits. This means that any claim for benefits must first be filed with the group insurance company providing coverage to your son/daughter through your employer or your spouse's employer. After they have paid all available benefits, our athletic accident insurance will consider remaining amounts based on USUAL and CUSTOMARY charges.

WE, AS THE SCHOOL, **DO NOT** HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE.

PLEASE NOTE:

1. Most employer's group insurance allows dependent coverage to be continued to age 25 if the dependent is a full-time student. **DO NOT** drop dependent coverage while your son/daughter is participating in intercollegiate athletics.
2. Claims against your group insurance plan **DO NOT** increase your individual insurance premiums.
3. Your son/daughter **MUST HAVE** primary insurance before participating in any sports activity at Central Arizona College.

**THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED, AND RETURNED.**

**Father/Guardian/Spouse/Self (PLEASE CIRCLE ONE)**

Name \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address \_\_\_\_\_  
(Street) (City, State, Zip)

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(Street) (City, State, Zip)

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Name of Group Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_ Telephone # \_\_\_\_\_

Does your insurance require: A second opinion for surgery? YES NO  
Pre-authorization for services? YES NO

Is your primary insurance an HMO? YES NO

Is your primary insurance a PPO? YES NO

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

**Mother/Guardian/Spouse/Self (PLEASE CIRCLE ONE)**

Name \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address \_\_\_\_\_  
(Street) (City, State, Zip)

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(Street) (City, State, Zip)

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Name of Group Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_ Telephone # \_\_\_\_\_

Does your insurance require: A second opinion for surgery? YES NO  
Pre-authorization for services? YES NO

Is your primary insurance an HMO? YES NO

Is your primary insurance a PPO? YES NO

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

**Please check one of the following:**

\_\_\_\_\_ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by \_\_\_\_\_.

\_\_\_\_\_ My son/daughter is NOT covered under my group insurance and/or has no insurance coverage. I understand that I am responsible for any medical bills not covered by the secondary (supplemental) accident only insurance.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_



Signal Peak Campus  
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## HIPPA Waiver

I, \_\_\_\_\_ understand that if I sustain an injury while playing in an intercollegiate activity (practice or competition), that I am covered under the HIPPA guidelines where no one person on the sports medicine staff can discuss my injury or past injuries with anyone else, including current coaches and other teammates, unless my permission is given. In addition, no members of the sports medicine team can disclose any previous and/or current injuries and treatments that I am currently experiencing to professional scouts or other colleges that might ask for them unless my permission is given.

**Please mark one:**

I hereby give permission to the Head Certified Athletic Trainer to discuss injuries and/or conditions to current coaches, medical personnel for further treatments, and other associated Certified Athletic Trainers at Central Arizona College.

I do NOT give my permission for anyone at Central Arizona College to discuss my injuries and/or conditions with current coaches, medical personnel for further treatments, and other associated Certified Athletic Trainers

Sport: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Printed)

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

**\*Signature of parent/guardian if under 18 years of age:**

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





## Central Arizona College Athletic Training

### Concussion Policy

It is the goal of Central Arizona College to provide the best care possible to all student-athletes participating in intercollegiate athletics. The following comprehensive concussion policy has been developed in an effort to maintain the highest standard of care in the treatment of cerebral concussion injuries.

#### Concussion Definition

A concussion is a disturbance in brain function that occurs following either a blow to the head or as a result of the violent shaking of the head which results in a wide range of physical, cognitive, emotional and/or sleep related symptoms. As described in the NCAA Sports Medicine Handbook, a concussion is a “complex physiological process affecting the brain induced by traumatic biomechanical forces.” While most concussion injuries are a result of a direct blow to the head, a concussion may also result from a force elsewhere to the body that is transferred to the head.

#### Second Impact Syndrome (SIS) Definition

Second Impact Syndrome (SIS) occurs when an athlete, who has already sustained a head injury, sustains a second head injury prior to complete resolution of symptoms from the first injury (including post-concussion syndrome symptoms). The second injury (even a mild injury to the head results in the loss of autoregulation of the blood supply in the brain leading to excessive swelling of the brain and increased intracranial pressure causing the brain to herniated through the skull. Second Impact Syndrome occurs when a person has returned to participation too soon and a second injury to the head occurring days or even weeks after the first head injury. It may take days and weeks for concussion symptoms to resolve.

#### Neurocognitive Testing (ImPACT Test)

While a neuroimaging examination (MRI, CT, EEG) of a concussive injury is important to rule out physical intracranial injury, this examination will not determine the effects of a concussion. The reason for this issue is that concussion is a metabolic rather than structural injury. Thus, structural neuroimaging techniques are insensitive to the effects of concussions.

The ImPACT neurocognitive test is given as a pretest to all athletes in the sports of Volleyball, Basketball, Baseball, Softball, Cross Country, & Track & Field to provide a baseline measure in case of injury. If injured, the athlete will take the ImPACT neurocognitive test again for comparative purposes. Post-testing with ImPACT may continue as indicated by physician until results are similar to baseline test.

## Concussion Signs and Symptoms

Common Signs	Common Symptoms (*felt by athlete)
<p>Appears to be dazed or stunned</p> <p>Confused about assignment</p> <p>Unable to remember plays</p> <p>Unsure of game, score, opponent</p> <p>Slow to answer questions</p> <p>Moves clumsily</p> <p>Loses consciousness</p> <p>Vomiting</p> <p>Shows behavior or personality changes</p> <p>Can't recall events before the injury</p> <p>Can't recall events after the injury</p>	<p>*Headache</p> <p>*Nausea</p> <p>*Dizziness or balance problems</p> <p>*Double or fuzzy vision or any other visual alteration</p> <p>*Sensitivity to light and/or noise</p> <p>*Feeling sluggish or slow</p> <p>*Feeling "foggy" or groggy</p> <p>*Concentration or memory problems, confusion</p> <p>*Extreme fatigue</p>
Observed by Athletic Trainer/Coach/Parent	Felt by Athlete

## Treatment Protocol

All athletes suspected of sustaining a concussion will follow this treatment protocol without exception.

1. Removal from activity (contest/practice) following signs and symptoms of concussion
2. No return to play in current activity (contest/practice)
3. Medical Evaluation following injury
  - a. Rule out serious intracranial injury
  - b. Neurocognitive Testing
4. Stepwise Return-to-Play guidelines
  - a. No activity and rest until asymptomatic (including post concussion symptoms)
  - b. Light aerobic exercise (may not begin until Neurocognitive test returns to normal)
  - c. Sport Specific Training
  - d. Non-contact drills
  - e. Full-contact drills
  - f. Resume game play

## Concussion Statement/ImPACT Test Agreement

As a student-athlete at Central Arizona College, I understand that it is my responsibility to report all known possible concussions and head injuries to the Athletic Training Staff. Failure to do so may result in removal from the Central Arizona College athletic program.

As a student-athlete at Central Arizona College, I give my consent for neurocognitive testing using the ImPACT test. I understand that this test will be used as a baseline measure in case I sustain a concussion. This ImPACT test will then be used post injury in conjunction with other information to help determine a safe return to play.

ImPACT neurocognitive testing is required for participation in the following sports and activities: Volleyball, Cross Country, Men's & Women's Basketball, Baseball, Softball, & Men's & Women's Track and Field

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Sport

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Name (Print)

---

Signature

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Date