



McHenry County College

Athletic Department
8900 US Hwy. 14
Crystal Lake, IL 60012
815-455-8580

Dear Student-Athlete,

Prior to your participation in Intercollegiate Athletics the following forms must be completed:

Please use black ink, making sure **ALL** areas on forms are **COMPLETE.**

1. Physical Exam
 - Before being cleared to participate, each student-athlete must undergo a Pre-participation Physical Evaluation by a **MD, DO, PA or NP.**
2. Athletes Medical History
 - This form supplies our Athletic Trainer with current medical history.
3. Student Medical Emergency and Insurance Information
 - This form provides emergency information, emergency contacts, and insurance information about the student-athlete.
4. First Agency Parent/Guardian/Student Information Form – For Insurance Company
 - The front of form provides all information to insurance company on the athlete and parent/guardians.
 - The back of form permits the insurance company to discuss and release, pertinent medical information with physicians and insurance companies.
 - **Student and Parent/Guardian sign back of form.**
5. NJCAA Eligibility Affidavit
 - This form aids in determining your eligibility.
6. Student-Athlete Academic Information Sheet

This form provides information to our Coordinator of Student-Athlete Success.
7. Medical and FERPA Release Form
 - Student consent to release educational/medical information.
8. Official High School transcript with graduation date and official transcripts from any college(s) attended.

You will not be able to participate until forms are completed and submitted to the Athletic Department (A127a)

PHYSICAL EXAMINATION

TO BE COMPLETED BY A MD, DO, PA OR NP

Forms completed by other practitioners will not be accepted

Student-Athlete Name: _____

Forms with blanks will not be accepted

Height FT IN Weight Pulse B/P

Visual Acuity L R
Wearing Contacts/Glasses Yes No

<u>MEDICAL EXAMINATION</u>	<u>OK</u>	<u>ISSUE</u>	<u>COMMENT</u>
Skin & Scalp			
Head & Neck			
Eyes/Fundus			
Ears, Nose, Throat			
Lymphatics			
Dental			
Thorax			
Lungs			
Heart: Pericardial Activity			
Standing/Supine			
Murmur			
Abdomen			
Hernia			
<u>ORTHOPEDIC EXAMINATION</u>	<u>OK</u>	<u>ISSUE</u>	<u>COMMENT</u>
Neck & Shoulder			
Elbow, Hand & Wrist			
Back			
Knee			
Ankle			
Feet			
Flexibility			
Other			
Neurologic			

REFERRAL OR f/u PLAN:

- ATC MD/DIAGNOSTIC TESTS: _____
- LAB MEDICAL RECORDS: _____
- X-RAY OTHER: _____

CLEARANCE

- Full Unlimited Athletic Participation _____
- Not Cleared - Notes/Limitations: _____

Examiner Name Printed: _____
Examine must be performed or signed by MD/DO/PA/NP

MD DO PA NP

Examiner Signature: _____

Date: _____

Phone Number of Doctors Office/Clinic: _____

Doctors Office/Clinic Stamp

If there is NO office/clinic stamp,
Please attach the MD/DO/PA/NP
business card. Thank you.



STUDENT-ATHLETE MEDICAL HISTORY

Forms with blanks will not be accepted

Student-Athlete Name: _____

Sport(s): _____ Birth Date: _____ Male Female

1. Past Medical History

Have you ever been told you have a heart condition or heart murmur? YES NO

Have you been told you have high blood pressure? YES NO

Has anyone in your family died suddenly before age 50? YES NO

(including grandparents, aunts, uncles cousins)

2. Have you ever had any of the following problems during or after exercise?

Passing out YES NO Excessive chest pain YES NO

Asthma attacks YES NO Excessive coughing YES NO

Light headedness/dizziness YES NO Extreme shortness of breath YES NO

Unusual racing heart or skipping heartbeats YES NO Do you get tired more quickly than your friends YES NO

3. INJURIES Have you ever had:

Concussion YES NO

Neck pain/injury YES NO

Muscle Injury YES NO

Joint Sprains YES NO

Broken bone YES NO

Hernia YES NO

Back pain/injury YES NO

Dislocations YES NO

Any current pain/problems YES NO

4. MEDICAL: Have you ever had:

Heat stroke/heat exhaustion YES NO

Asthma YES NO

Diabetes YES NO

Mononucleosis YES NO

Blood Disorder YES NO

Seizures/Epilepsy YES NO

Allergies YES NO

Types of Allergies: _____

4. Previous Surgeries: YES NO If YES, please explain: _____

5. In the past, have you been disqualified or unable to participate in sports due to injury or sickness? YES NO

If YES, please explain: _____

6. Are you currently taking any medications or supplements? YES NO

If YES, please list: _____

The above information is correct. _____ Date: _____

Student-Athlete's signature

Parent's/Guardian's signature: _____ Date: _____

(Required if Student-Athlete is under 18 years of age)



RISK/INJURY REPORTING/INSURANCE CLAIMS

- When voluntarily participating in athletics/athletic related travel at McHenry County College, student-athletes understand that there are inherent risks and hazards. Injuries incurred could be severe, including but not limited to fracture, paralysis, or even death. MCC is concerned about the health, safety and welfare of our student-athletes. They should report unsafe practices, facilities, conditions or activities to the Director of Athletics.
- Student-Athletes are responsible for immediately reporting all injuries sustained as a direct result of official MCC athletic participation to the Head Coach and/or athletic trainer. They will confirm that an injury/incident report has been filed by the athletic trainer, or Head Coach with the Athletic Offices. Incident report is used to justify any future medical payments that may need be considered for payment by the college's secondary policy. Secondary injury insurance coverage is only provided for injuries incurred as a direct result of participation in official MCC practices and events. Coverage is not provided during voluntary off season workouts, open gyms.
- During the approved regular season, McHenry County College provides secondary injury insurance for all certified student-athletes. Secondary insurance means that if an athlete *is not* insured by a primary (personal or family) medical insurance policy, McHenry County College's injury policy may become primary for costs incurred due to an accident or injury sustained while participating in an official/approved in-season college athletic activity.
- Student-athletes who do not turn in the insurance form will not be allowed to submit McHenry County College injury bills for secondary insurance coverage consideration.

CLAIM PROCEDURE

All medical bills incurred by a student athlete as the result of an injury in the intercollegiate sports program will be sent directly to their home address.

A. Submit the bills incurred to the student's primary insurance company or the family employer group coverage or plan FIRST. They will do one of two things:

1. Honor the claim and pay all or a portion of the bills incurred.
2. Not honor the claim and send you a letter of denial.

B. If there remains a balance after the student's personal or the family employer group insurance or plan has contributed towards the claim, the student athlete should bring the itemized claim sheet from the insurance company, an "Explanation of Benefits" (EOB), and copy of the itemized bills to the Athletic Offices, who in turn, will submit to MCC's Office of Business Services. Submitting of this paperwork should be done within **2 weeks** of receiving the outstanding bills.

C. If the bills incurred are not paid by the student's personal or the family or employer group insurance or plan, the claim will be sent from our insurance carrier office for processing. Claims must be initiated by the athlete within **60 days** of the date of the injury. If the insurance carrier needs any additional information, please cooperate with them. They will process the claim in the least possible amount of time. It is in your best interest to have the claim settled promptly since all bills incurred are in the student's name.

ATHLETE MEDICAL EMERGENCY AND INSURANCE INFORMATION

Forms with blanks will not be accepted

Sport(s): _____

Student Athlete Name: _____ Please print ID#: _____

Current Address: _____ Street Apt/unit Phone: _____

City State Zip Code Date of Birth: ____ / ____ / ____

Email Address: _____ Gender: ___ Male ___ Female

List any medications you have allergies to: _____

List any medical conditions and any medications you are currently taking: _____

EMERGENCY CONTACT	EMERGENCY CONTACT
Name: _____	Name: _____
Relation: _____	Relation: _____
Home Address: _____ Street	Home Address: _____ Street
City State Zip Code	City State Zip Code
Home/Cell Phone: _____	Home/Cell Phone: _____
Employer: _____	Employer: _____
Employer Address: _____ Street	Employer Address: _____ Street
City State Zip Code	City State Zip Code
Work Phone: _____	Work Phone: _____

INSURANCE INFORMATION
Do Not Leave Any Blanks

Policy Holders Name: _____ (Name on Insurance Card) Type of Insurance
 HMO PPO Other _____

Insurance Company: _____

Policy/ID #: _____

Group #: _____ Is preauthorization necessary for medical/diagnosis services?
_____ Yes _____ No

Insurance Company Phone #: _____

I HAVE NO PRIMARY INSURANCE COVERAGE : _____ Signature _____ Date _____



First Agency, Inc.
 5071 West H Avenue
 Kalamazoo, MI 49009-8501

PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University _____

Attention _____

This form is to be completed by the
 Parents, Guardians or Student.

Address _____

City _____ State _____ Zip _____

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.
 If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____

Social Security No. or Passport No. _____ Date of Birth _____

Please note that the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

College Address _____ College Phone (_____) _____

Home Address _____ Home Phone (_____) _____

City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION	MOTHER/GUARDIAN INFORMATION
Father's Name _____	Mother's Name _____
Social Security No. _____	Social Security No. _____
Date of Birth _____	Date of Birth _____
Address _____ _____	Address _____ _____
Employer _____	Employer _____
Address _____ _____	Address _____ _____
Telephone (_____) _____	Telephone (_____) _____
Medical Insurance Company or Plan _____	Medical Insurance Company or Plan _____
Address _____ _____	Address _____ _____
Policy Number _____	Policy Number _____
Telephone (_____) _____	Telephone (_____) _____
Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM



First Agency, Inc.
 5071 West H Avenue
 Kalamazoo, MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I, or my authorized representative, is entitled to receive a copy of this authorization upon request

This Authorization is valid from the date signed for the duration of the claim.

 Name of Claimant (please print)

 Name of Authorized Representative, or Next of Kin (please print)

 Signature of Claimant (if claimant is 18 or older)

 Date

 Signature of Authorized Representative or Next of Kin

 Date

 Relationship of Authorized Representative or Next of Kin to Claimant



NJCAA Eligibility Affidavit

SPORT: _____ Date: _____

Complete **ALL** information to assist in determining **NJCAA** eligibility
(Please Print)

PERSONAL INFORMATION

Name: _____ Birth Date: ____/____/____ Student ID: _____
(First, Middle, Last)

Home Phone: _____ Cell Phone: _____

Email: _____

College Address: McHenry County College 8900 US Hwy 14 Crystal Lake, IL 60012 815-455-8580

OTHER INFORMATION

Parent's/Guardian's Name(s): _____

Parent's/Guardian's Home Phone: _____

Parent's/Guardian's Home Address: _____
Street Address City State Zip Code

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

HIGH SCHOOL INFORMATION

High School(s) attended: _____

City, State & Country: _____

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

Were you home schooled? Yes* No *If yes, did you graduate? Yes No

Did you earn a GED or state department of education approved high school equivalency test? Yes* No

*If yes, enter the Date Earned (month/year): ____/____

A copy of your OFFICIAL High School Transcript, with graduation date, and GED Certificated or state department of education approved high school equivalency test, with completion date, must be on-file with the Admissions Office prior to your participation.

ADDITIONAL INFORMATION

1. Did you take any college credit classes while in high school? Yes* No

* If yes, from what college(s)? _____

*** If yes, OFFICIAL transcript(s) from each college must be on file with the Admissions Office prior to participation.**

2. Have you ever signed a Letter of Intent form with any institution? Yes* No

*If yes, specify the College: _____ Date (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, provide the following.

Dates of that season: _____

Name of college: _____

Describe the situation: _____

ADDITIONAL INFORMATION (continued)

5. Have you ever participated in practices, scrimmages, and/or games for an intercollegiate team other than this college?
 Yes* No *If yes, provide the following.
 School(s): _____
 Sport(s): _____
 Date(s): _____
 Describe the situation: _____
6. Have you ever played on a club team at a college or university?
 Yes* No *If yes, provide the following.
 School(s): _____
 Sport(s): _____
 Date(s): _____
7. Do you currently play on any other sport teams (i.e. USAV, city recreational leagues, indoor soccer, AAU, etc.)
 Yes* No *If yes, provide the following.
 Name of team: _____
 Location: _____
 Date(s) 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. _____

ADDITIONAL EXPLANATIONS

THE NJCAA REQUIRES YOU TO ACCOUNT FOR ALL TIME THAT HAS LAPSED SINCE ATTENDING HIGH SCHOOL, INCLUDING FULL AND PART-TIME COLLEGE ATTENDANCE, MILITARY SERVICE, CHURCH SERVICE AND EMPLOYMENT. PLEASE ACCOUNT FOR ALL TIME ON THE HISTORY BELOW. If none of the previously mentioned activities apply, indicate dates and specify "did not work – did not go to school."

INCOMPLETE FORMS WILL BE RETURNED

PLEASE START AFTER HIGH SCHOOL GRADUATION DATE IN CHRONOLOGICAL ORDER

Begin Date		End Date		College/Employer/Activity	City	State	Full or Part Time
Month	Year	Month	Year				

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. I authorize the college to release my transcripts to the NJCAA and college officials involved in the determination of and compliance with athletic eligibility.

Student-Athlete Signature: _____ Date: _____

Coach Signature: _____ Date: _____

MCHENRY COUNTY COLLEGE STUDENT-ATHLETE ACADEMIC INFORMATION SHEET

(PLEASE PRINT LEGIBLY USING BLACK INK)

NAME: _____ SPORT(S): _____
LAST FIRST MI

CURRENT ADDRESS: _____
NUMBER STREET CITY STATE ZIP

SEX: M F DATE OF BIRTH: ____/____/____ STUDENT ID # (if assigned) : _____

CELL PHONE NUMBER: _____ HOME PHONE NUMBER: _____
[Grid for phone numbers]

IS IT OK FOR THE MCC ATHLETIC DEPARTMENT TO CONTACT YOU VIA TEXT MESSAGING? YES _____ NO _____

PRIMARY E-MAIL ADDRESS: _____
[Grid for email address]

WILL YOU HAVE YOUR OWN VEHICLE TO GET YOU TO AND FROM CAMPUS? YES _____ NO _____

HIGH SCHOOL: _____ YEAR GRADUATED: _____
MONTH YEAR

NAME OF PREVIOUS COLLEGES ATTENDED IF APPLICABLE (please list more recent first):

DATES FROM: _____ TO: _____

DATES FROM: _____ TO: _____

*****If you have attended another college you will need those official transcripts sent to MCC for credit evaluation.**

HIGH SCHOOL OR COLLEGE GPA (ON A 4.0 SCALE) CHECK ONE: _____
_____ 3.50 – 4.00
_____ 3.00 – 3.49
_____ 2.50 – 2.99
_____ 2.00 – 2.49
_____ BELOW 2.00

ACT SCORE (IF KNOWN): _____

ACADEMIC SUBJECTS YOU FIND THE EASIEST OR PERFORM BEST IN:

ACADEMIC SUBJECTS YOU HAVE THE MOST DIFFICULTY WITH:

DEGREE INTENT/INTENDED MAJOR (IF KNOWN): _____

WILL YOU BE WORKING DURING THE FALL AND SPRING TERM? IF SO, PLEASE LIST THE APPROXIMATE AMOUNT OF HOURS PER WEEK YOU PLAN TO WORK DURING EACH RESPECTIVE TERM:

FALL _____ SPRING _____

DID YOU ATTEND A HIGH SCHOOL OTHER THAN THE ONE YOU GRADUATED FROM? YES _____ NO _____



MEDICAL AND FERPA RELEASE FORM

The Family Educational Rights and Privacy Act of 1974, also known as FERPA and/or The Buckley Amendment of 1974, as amended, grants students and eligible parents certain rights and privacies regarding education records of students attending postsecondary institutions. By submitting this form, the student consents to release his/her educational/medical and/or other information for NJCAA eligibility and college recruiters.

STUDENT ATHLETE INFORMATION (Please print):	
Student Name: _____	Sport: _____

AUTHORIZATION FOR RELEASE OF RECORDS Academic Year: 2018 - 2019	
Records to be Released to	McHenry County College Athletics Staff
Academic Records/Grades	Includes all grades for courses including: GPA, credits earned, credits attempted, and degree(s) awarded included on the student's transcript record.
Authorization to Release Academic Records/Grades	Share academic information to a third party
Financial Aid	Includes financial aid information (Pell eligibility, EFC, AGI) and other determining factors related to federal student aid eligibility as this relates to determination of eligibility for financial and other support
Accounting	Includes tuition and fee balances, financial holds, mailing and billing address, payment plans, accounting statements, collections and debt information
Registration	Includes information and documents related to current enrollment, dates of enrollment activity, enrollment status, residency status, semesters attended and mailing address information
Medical Records	MCC Athletics Staff and Trainer to obtain my Medical Records from my family, legal guardians, coaches, physicians, physicians representatives, insurance providers, and health care providers regarding injuries, conditions, medical claims, treatments, drug testing, or any related matters.
Authorization to Release Medical Records	MCC Athletics Staff and Trainer to share the necessary personally identifiable information from my medical record to a third party regarding (i) past, present, or future injuries/illnesses related to my participation in Intercollegiate Athletics, (ii) information within my medical record unrelated to my participation in Intercollegiate Athletics, and (iii) information concerning my medical status, medical conditions, injuries, prognosis, drug tests, and other documentation and information regarding my health (collectively, "Medical Records")

I give permission to release/disclose the information above, from my educational/medical records, for the duration of the academic year.

Student Signature: _____

Date: _____