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 From
   - 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 ☐

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

REFERRALL 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: _____ MD DO PA NP
Examine must be performed or signed by MD/DO/PA/NP

Examiner Signature: _____ Date: _____

Phone Number of Doctors Office/Clinic: _____

Doctors Office/Clinic Stamp

If there are any questions, contact the MCC Athletic office at 815-455-8580.

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? (including grandparents, aunts, uncles cousins)	☐ YES	☐ NO

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)

ATHLETE MEDICAL EMERGENCY AND INSURANCE INFORMATION

Forms with blanks will not be accepted

Sport(s): _____ _____

Student Athlete Name: _____ ID#: _____

Please print

Current Address: _____ Phone: _____

Street Apt/unit

_____ Date of Birth: ____/____/____

City State Zip Code

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

Father's Name _____

Social Security No. _____

Date of Birth _____

Address _____

_____

Employer _____

Address _____

_____

Telephone (_____) _____

Medical Insurance
Company or Plan _____

Address _____

_____

Policy Number _____

Telephone (_____) _____

Is this plan an HMO or PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ No

MOTHER/GUARDIAN INFORMATION

Mother's Name _____

Social Security No. _____

Date of Birth

Address _____

_____

Employer _____

Address _____

_____

Telephone (_____) _____

Medical Insurance
Company or Plan _____

Address _____

_____

Policy Number _____

Telephone (_____) _____

Is this plan an HMO or PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ 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					Full or Part Time
Month	Year	Month	Year	College/Employer/Activity	City	State	

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:

IS IT OK FOR THE MCC ATHLETIC DEPARTMENT TO CONTACT YOU VIA TEXT MESSAGING? YES_____ NO_____

PRIMARY E-MAIL 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: 2017 - 2018	
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: _____