

## LIGHTHOUSE CHRISTIAN COLLEGE NEW ATHLETE MEDICAL HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Sport: \_\_\_\_\_ men's or women's Cell Phone \_\_\_\_\_

**INSTRUCTIONS:** Lighthouse Christian College requires all athletes to have a yearly physical examination and primary medical insurance. An athlete cannot participate until all paperwork is completed and on file in the athletic training department. Further, the College does not assume any responsibility for medical bills incurred. Athletes must maintain primary, major medical insurance, which provides coverage for injuries sustained in intercollegiate athletics.

### EMERGENCY NOTIFICATION INFORMATION

#### Person to notify in case of an emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

### INSURANCE INFORMATION

Policy Holder's Name: \_\_\_\_\_  
(Last) (First) (MI) Date of Birth \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ ID # \_\_\_\_\_

**INSURANCE MUST COVER INTERCOLLEGIATE ATHLETICS** Is your primary insurance an HMO PPO

If you have Medicaid or an HMO as your primary health insurance, please be aware coverage may vary depending on which state you receive care in. Some insurance companies do not provide coverage for non-emergency care if it is received outside of your home state or insurance network. Please contact your insurance carrier to verify coverage in the State of Florida. If your insurance does not provide full coverage in Florida, it is recommended you obtain coverage which does cover you in Florida. Insurance coverage must be maintained for the full school year to be cleared to participate. Any change or loss of coverage must be immediately reported to the athletic training staff.

I hereby acknowledge I have read and understand the requirements for sports participation and an insurance plan. I also acknowledge the above information is accurate and correct to the best of my knowledge. I hereby authorize Lighthouse Christian College to inspect and secure copies of medical records, laboratory reports, diagnoses, x-rays, and other data covering any confinements or disability related to any injuries from participation and/or any previous confinements and/or disabilities. A photocopy or facsimile of this authorization shall be deemed as valid as the original until revoked by me in writing.

I grant the athletic trainers, team physicians, coaches, and consultants of Lighthouse Christian College to render me any emergency care, or other medical or surgical care which might be deemed necessary to insure proper care of any injury/illness, and to maintain my health and wellbeing. In the absence of the team or authorized physician, I grant permission to a qualified physician to furnish emergency care using the guidelines above. Also, when necessary for executing such care, permission for hospitalization at an accredited hospital is granted.

\_\_\_\_\_  
Athlete Printed Name

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (Required if athlete is less than 19)

\_\_\_\_\_  
Date

**FAMILY MEDICAL HISTORY:** Has any immediate family member ever had?

Cancer	YES	NO	Stroke	YES	NO	Sickle Cell Trait/Disease	YES	NO
Diabetes	YES	NO	Epilepsy/Seizures	YES	NO	Die suddenly before age 50 years	YES	NO
Heart Trouble	YES	NO	Mental Illness/Depression	YES	NO			
High Blood Pressure	YES	NO	Suicide	YES	NO			

Other, please explain:

**MEDICAL ILLNESS HISTORY**

Have you ever had or do you now have any of the conditions below?

CHECK EACH ITEM	YES	NO	AGE	CHECK EACH ITEM	YES	NO	AGE	CHECK EACH ITEM	YES	NO	AGE
Palpitation or Pounding Heart				Ear, Nose, or Throat Trouble				Hypoglycemia (low blood sugar)			
High Blood Pressure				Kidney Trouble				Diabetes			
Heart Problems/Murmur				Intestinal Trouble				Psychiatric Problems			
Chronic Cough				Liver Trouble				Depression			
Pain/Pressure in Chest				Hernia				Insomnia			
Shortness of Breath				Gall Bladder Trouble				Neuritis			
Asthma				Appendicitis				Seizures			
Bronchitis				Bloody Urine				Dizziness			
Glaucoma				Tumor/Growth/ Cyst				Amnesia			
Retinal Detachment				Cancer				Sickle Cell Anemia			
Heat Exhaustion				Mononucleosis				Fainting			
Heat Stroke				Anemia				Lyme Disease			

**GENERAL MEDICAL ALLERGIES:** Please answer as to whether you are allergic to the following items?

Aspirin	YES	NO	Naproxen	YES	NO	Sulfa Drugs	YES	NO	Peanuts/tree nuts	YES	NO
Penicillin	YES	NO	Ibuprofen	YES	NO	Bee/Wasp stings	YES	NO	Shellfish	YES	NO
1. If you answered yes to any of the allergies above, do you carry an Epi-Pen auto injector?										YES	NO
2. Do you carry an inhaler for breathing problems?										YES	NO
3. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:										YES	NO

**GENERAL MEDICAL INFORMATION:** (CIRCLE THE CORRECT ANSWER)

1. Have you ever been tested for sickle cell trait?								YES	NO
• If yes, were the results <b>Positive</b> or <b>Negative</b> ? (circle one)								S	
2. Have you ever had a Concussion? If yes, please list the number of times and the date of each:								YES	NO
3. Do you have a vision defect in either one or both eyes and if yes, please specify:								YES	NO
4. Do you wear glasses?				YES	NO	Do you wear contact lenses?		YES	NO
5. Do you wear any dental appliances?				YES	NO	If so, do you wear them during practice?		YES	NO
6. If yes, circle the appropriate appliance: Corrective Braces, Permanent Bridge, Permanent Crown or Jacket, Removable Partial or Full Plate									
7. Have you ever lost the full use of any organs, either temporarily or permanently? If yes, please list the organ(s) and details regarding the loss including the dates and treating physicians for each:								YES	NO
8. Have you ever had surgery to repair or remove any organ? If yes, please list the organ(s) and details regarding the repair and/or removal:								YES	NO

**Orthopedic Injuries:**

Have you ever had a fracture or dislocation? <b>YES NO</b> If yes, please indicate the body part in the chart below:			
BODY PART	DATES	BODY PART	DATES
SKULL		COLLAR BONE	
NOSE		UPPER ARM	
FACE		FOREARM	
JAW		WRIST	
NECK		HAND	
SPINE		THIGH	
PELVIS		LOWER LEG	
RIBS		FOOT	
SHOULDER		KNEE CAP	
ANKLE		ELBOW	
FINGERS		TOES	
If the fracture/dislocation required surgery, please explain.			
Please list any ligament, tendon or meniscus injuries you have had.			

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand this information is used to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses I may incur.

\_\_\_\_\_  
Athlete Printed Name

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (Required if athlete is less than 19)

\_\_\_\_\_  
Date

# Symptom Score Sheet

Have you ever had a concussion?    YES    NO  
 If yes, date of last concussion: \_\_\_\_\_

Please circle the number below which indicates the degree to which you are CURRENTLY experiencing the following symptoms: (Complete this section even if you have never had a concussion)

Symptoms	Symptom Severity Rating						
	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Lightheadedness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous/Anxious	0	1	2	3	4	5	6
Feeling more emotional	0	1	2	3	4	5	6
Numbness or tingling	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Visual Problems	0	1	2	3	4	5	6
Other	0	1	2	3	4	5	6

I understand I have a responsibility, and am required, to report any suspected concussions to a member of the athletic training department. I understand I cannot continue to practice or play if there is the possibility I have sustained a concussion, until I have been cleared by a member of the athletic training staff.

\_\_\_\_\_  
 Athlete Printed Name

\_\_\_\_\_  
 Athlete Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent Signature (Required if athlete is less than 19)

\_\_\_\_\_  
 Date

Lighthouse Christian College - Department of Athletics  
Assumption of Risk and Medical Waiver Form

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving **MANY RISKS OF INJURY**, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, concussions, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my body, general health and well-being.

Additionally, I acknowledge that COVID-19 is a public health risk, and the Lighthouse Christian College, LCC Athletics and all its trustees, officers, administrators, agents, employees and volunteers cannot guarantee safety or immunity from infection, and that I am electing to participate in intercollegiate athletics.

Because of the aforementioned dangers of participating in any athletic activity:

- I recognize the importance of following all instructions of the coaching staff, strength and conditioning staff, and/or Athletic Training staff. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics.
- I grant the athletic trainers, team physicians, therapists, technicians, and consultants of LCC to render me any emergency care, or other medical or surgical care that might be deemed necessary to insure proper care of any injury/illness, and to maintain my health and well-being. In the absence of the team or authorized physician, I grant permission to a qualified physician to furnish emergency care using the guidelines above. Also when necessary for executing such care, permission for hospitalization at a hospital is granted.
- I further understand that it is my responsibility to notify the LCC sports medicine staff in writing of any and all injuries/illnesses or physical condition, athletic or otherwise, suspected injury/illnesses or physical condition, and any and all pre-existing conditions that may result in further injury/illness to myself, teammates, opponents, or athletic/sports medicine staff.
- I understand that I must refrain from practice or play during medical treatment until I am discharged from treatment or given a written permit by the attending physician to resume participation; that having passed a 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; and fully realize that LCC cannot be held responsible for any medical condition(s) that I may have.

In consideration of LCC permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release Lighthouse Christian College and their officers, agents, and employees from any and all liability, any medical expenses, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at Lighthouse Christian College.

\_\_\_\_\_  
Athlete Printed Name

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (Required if athlete is less than 19)

\_\_\_\_\_  
Date

# Lighthouse Christian College

## Department of Athletics

### Athlete Concussion Statement

\_\_\_\_\_  
Initials I understand it is my responsibility to report all injuries and illnesses to my athletic trainer; including concussions.

\_\_\_\_\_  
Initials I was provided a copy of the NCAA Concussion Fact Sheet and am aware of the following information:

\_\_\_\_\_  
Initials A concussion is a brain injury, which I am responsible for reporting to my athletic trainer.

\_\_\_\_\_  
Initials A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep and classroom performance.

\_\_\_\_\_  
Initials You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

\_\_\_\_\_  
Initials If I suspect a teammate has a concussion, I am responsible for reporting the injury to my athletic trainer.

\_\_\_\_\_  
Initials I will not return to play in a game or practice if I have received a blow to the head that results in concussion-related symptoms.

\_\_\_\_\_  
Initials Following a concussion, the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms have resolved.

\_\_\_\_\_  
Initials In rare cases, concussions can cause permanent brain damage and even death.

\_\_\_\_\_  
Initials Helmets, face shields, mouth guards and other protective equipment does not eliminate the risk of a concussion.

\_\_\_\_\_  
Initials Purposeful head and neck contact is not permitted and increases my risk for suffering a head injury.

\_\_\_\_\_  
Initials Participation in any sport carries the risk of suffering a concussion

\_\_\_\_\_  
Athlete Printed Name

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (Required if athlete is less than 19)

\_\_\_\_\_  
Date

# Lighthouse Christian College Department of Athletics Medication List

Please list all prescription medications you are currently taking. Some medications may cause you to test positive for the NAIA drug test and you must have prior approval by the NAIA in order to compete while taking these medications. Failure to list medications could cause you to test positive, resulting in forfeiture of competitions. If you do not take any prescription medications write **None**, then sign and date the form.

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_  
6 \_\_\_\_\_  
7 \_\_\_\_\_  
8 \_\_\_\_\_  
9 \_\_\_\_\_  
10 \_\_\_\_\_  
11 \_\_\_\_\_  
12 \_\_\_\_\_

By signing below, I acknowledge I have provided an accurate list of all prescription medications I am currently taking. I also understand I must provide an updated list if I am prescribed any new medications.

\_\_\_\_\_  
Athlete Printed Name

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (Required if athlete is less than 19)

\_\_\_\_\_  
Date

# Lighthouse Christian College Consent for Treatment

I authorize Lighthouse Christian College to provide medical and/or mental care to:

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

In case of mental health concern, illness, or injury, permission is hereby granted to treat the above named student as deemed necessary by the staff of Lighthouse Christian College. Services may include but are not limited to routine and emergency medical services (including examinations; laboratory, radiologic and other testing vaccinations; minor surgical procedures; prescription and other treatments), and mental health services. I understand that, in the case of a minor child, should said minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated. I further understand that, according to Florida state law, that once an individual reaches the age of 19, parental consent for treatment is no longer required. Parent or guardian consent is not legally required for minors who seek medical diagnosis and treatment for sexually transmitted diseases.

To the best of my knowledge, the above information is accurate. I understand the information I provided will be used to assist medical personnel in case of emergency.

\_\_\_\_\_  
Athlete Printed Name

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (Required if athlete is less than 19)

\_\_\_\_\_  
Date

## Immunization Records

All entering students must show a valid immunization record (2 shots) for measles, mumps, and rubella (MMR).

# Lighthouse Christian College

## Department of Athletics

### Physical Exam

\*We do not accept physicals performed by chiropractors

NAME: _____	AGE: _____	SPORT: _____	DATE: _____
WEIGHT: _____	HEIGHT: _____	Vision: R: _____ / _____	L: _____ / _____

BLOOD PRESSURE:		PULSE:			
	NORMAL	ABNORMAL		NORMAL	ABNORMAL
HEAD			RESPIRATORY		
NECK			MOUTH, TEETH		
EYES			HEART		
EAR, NOSE, THROAT			CHEST, LUNGS		
NEUROMUSCULAR			GENITALIA, HERNIA		
SKIN			ABDOMEN		
MUSCULOSKELETAL (ROM, Strength, etc)					
NECK			HIPS		
SPINE			THIGHS		
SHOULDERS			KNEES		
ARMS, HANDS			ANKLE, FEET		
Physicians Comments:					

**OVERALL PHYSICAL EXAMINATION RESULTS:**

<b>PASSED WITHOUT LIMITATIONS</b>	
<b>PASSED PENDING THE FOLLOWING</b>	

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MD, DO, PA, or NP only

Physician's Printed Name or Stamp: \_\_\_\_\_