San Bernardino Community College District
CRAFTON HILLS COLLEGE

SPORT: _____

Athlete Name: _____

Dear Student Athlete/Parent/Guardian:

We would like to welcome your athlete to the San Bernardino Community College District Athletic Program at Crafton Hills College (CHC). In order to make his or her participation more enjoyable and fulfilling, we are attaching a general information sheet explaining athletic policies and procedures.

Bylaw 3.5 of the California Community College Athletic Association Constitution requires all student-athletes shall complete a thorough pre-participation examination (PPE) prior to any practices or any intercollegiate competitions. This screening shall be performed by a medical doctor (MD) or doctor of osteopathic medicine (DO) licensed and in good standing in his or her state or other qualified medical personnel who are under a MD's or DO's supervision. A MD or DO must sign the PPE Form. If a PA or NP completes the form a facility stamp must be included at the bottom of the form.

The College (CHC) would like to notify you that athletic insurance coverage provided to athletes of Crafton Hills College is in compliance with the Education Code Sections 32220-24. Coverage is provided on an "excess" or secondary basis to your own private insurance coverage. The policy is not intended to pay medical bills covered by other insurance until your insurance carrier pays the maximum amounts.

Limit of coverage for intercollegiate athletic accidents is $100,000 accidental medical expense and $1,500.00 accidental death. The policy has limitations and it is important for you to read the insurance information that is provided to your athlete. One hundred percent coverage is not available in all cases.

Notification of injury must be filed with the coach or athletic director within 24 hours of the time of injury, whether you do or do not have you own insurance coverage. Claim form must be completed, signed and submitted to Student Insurance as well as to your own private insurance carrier. (It is the responsibility of the athlete or parent/guardian to furnish the hospital and/or physician with the proper insurance identification and/or claim form from the parent's insurance carrier. Failure to do so will cause needless delay in the settlement of the claim and may hinder your credit rating). When your private insurance carrier has made payment, please send a copy of their notification to Student Insurance so that any balance due can be cleared. If the athlete has no other valid collectible insurance coverage, student insurance will respond for the full eligible amount.

To assist the Insurance Company in processing claims we are enclosing an insurance verification sheet, which must be completed fully and returned to the Athletic Trainer prior to issuance of athletic equipment. NO EQUIPMENT/UNIFORMS WILL BE ISSUED UNTIL THIS FORM IS RETURNED COMPLETED TO THE ATHLETIC STAFF.

It is important to bear in mind that the college cannot be responsible for medical treatment or hospitalization not previously referred by officials of the college. In addition, the college does not assume responsibility for any pre-exiting conditions or any other conditions not directly related to intercollegiate sports competition at CHC. To guard against accident in travel, all members of athletic teams must use transportation provided by the college in going to and from athletic contest

No liability on the part of the college exists or may be assumed to exist for any amount beyond the limits of any policy carried by the college. No liability on the part of the college exists or may be assumed to exist for off-campus medical, dental treatment or hospitalization of any kind, for athletic injuries without prior referral by the team doctor or in his/her absence the athletic trainer, director or dean.

Yours very truly,

Heather Chittenden

Athletics Director

This is to acknowledge that we have read and understand the above statements and agree to abide by its provisions as it pertains to competing in the intercollegiate sports program at Crafton Hills College.

Athlete Name: _____

Athlete Signature Date

Parent Signature Date

San Bernardino Community College District
Crafton Hills College Athletics

VOLUNTARY ACTIVITIES PARTICIPATION FORM
ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

I, _____, wish to participate in the following athletic activity: _____

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness/death to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses/death, which may result from participating in these activities, include, but are not limited to, the following:

1. Sprains/strains
2. Fractured bones
3. Head/Concussion
4. Spine injuries
5. Paralysis
6. Loss of eyesight
7. Communicable diseases
8. Death

I understand and acknowledge that participation in these activities is voluntary and as such is not a requirement of the College or District.

I understand and acknowledge that in order to participate in these activities; I agree to assume liability and responsibility for any and all potential risks, which may be associated with participation in such activities.

I understand, acknowledge, and agree that the college or District, its employees, officers, agents, or volunteers shall not be liable for any injury/illness/death suffered by me which is incident to and/or associated with preparing for and/or participating in this activity.

I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES PARTICIPATION FORM and that I understand and agree to its terms.

_____

Participant's Signature Date

Participant's Printed Name: _____

_____

Parent/Guardian Signature (if participant under 18 years of age) Date

This signed VOLUNTARY ACTIVITIES PARTICIPATION FORM must be on file with the College/District before a student is able to participate in the above extra-curricular/co-curricular activity.

CRAFTON HILLS COLLEGE ATHLETIC INSURANCE POLICIES AND PROCEDURES

I. GENERAL INFORMATION

A. Athlete's personal insurance will be the first company billed whenever claims involve inpatient hospitalization and/or surgery and any outpatient claims over $250.00. What is not covered by personal insurance will be cleared by the college insurance.

B. All athletes are provided with an outline for our college's insurance policy and at any time can pick up another copy from the athletic trainer. The outline lists the coverage and responsibilities of the college.

C. Athletes are required to pass a physical before the college, athletic department, and athletic trainer take responsibility for any injuries. Athletes are not permitted to participate in workouts/competition until the trainer receives verification the athlete has passed a physical by a physician.

D. The college is not responsible for any pre-existing injuries or physical disorders discovered during the athletic physical by the attending physician. Pre-existing injuries and physical disorders would include such items as joint disorders, back problems, high blood pressure, concussions, etc. Any athlete with any disorder of significant magnitude resulting in failure to pass the physical will be referred to the Athletic Trainer. The athlete is not permitted to participate until the proper medical clearance is provided to the trainer and approved by the Athletic Director.

E. Injuries are to be immediately reported to the trainer in which case the injury will be properly documented and reported to the insurance carriers within 20 days of injury. The college, its employees and its carriers are not responsible for injuries not reported or documented within the time limit.

II. ATHLETE'S OBLIGATIONS BEFORE PRACTICE OR PARTICIPATION

A. Return insurance verification form indicating personal or family insurance coverage.

B. Return medical release form for emergency medical treatment, signed by the athlete of legal age or by parent/guardian of minor age.

C. Supply verification of physical performed by College Physician (a fee will be charged) or physical performed by personal physician.

D. Report complete accurate physical history on the form provided during physicals.

III. INSURANCE CLAIM PROCESS

A. Athlete will report injury sustained in practice or competition to trainer within 24 hours of injury.*

B. Trainer determines proper course of action.
   1. Doctor referral (see "C" below)
   2. College treatment program

C. If referral is made to a physician, the following steps will be adhered to:

   1. Athletes will choose between team and/or personal physician.
   2. Student accident report will be completed by trainer.
   3. Athlete will take the original of the student accident report form when a visit is made to attending physician, as selected (College is not responsible for transportation)
   4. Athlete will initiate appropriate action with personal or family insurance company for claim payment to physician within 24 hours.*
   5. The trainer will retain a copy of student accident report and a photocopy will be placed on file in the Business Office.
   6. Athlete will report to trainer within 48 hours after diagnosis by physician.*
   7. The attending physician will send the student accident report to the college insurance carrier.
   8. College insurance carrier will contact athlete's private insurance company to confirm and coordinate payment of claim.
   9. College insurance carrier will return copy of claim itemization payment to trainer.

D. Athlete can return to practice or competition only after release from attending physician is on file in the trainer's office.

NOTE:

1. Any questions regarding insurance or injuries by athlete or parents should be directed to the head Athletic Trainer or Athletic Director.

2. The college insurance policy is secondary and neither the college nor insurance carrier is responsible to pay complete eligible benefits unless the athlete has no primary insurance.

3. The college will be liable only for the limits specified in the college insurance policy.

* The Athletic Director must approve any extension of the 24 or 48-hour time limit.

VERIFICATION OF INSURANCE

My Name: _____

My Employer:_____ Telephone:_____

Address:_____

Individual or Group Insurance Company: _____

Policy Number _____

Yes ☐ I am covered by this policy No ☐ I am not covered by this policy

Social Security or Certificate Number _____

Spouse's Name: _____

Spouse's Employer:_____ Telephone:_____

Address:_____

Individual or Group Insurance Company: _____

Policy Number _____

Yes ☐ I am covered by this policy No ☐ I am not covered by this policy

Social Security or Certificate Number _____

Father's Name: _____

Father's Employer:_____ Telephone:_____

Individual or Group Insurance Company: _____

Policy Number _____

Yes ☐ I am covered by this policy No ☐ I am not covered by this policy

Social Security or Certificate Number _____

Mother's Name: _____

Mother's Employer:_____ Telephone:_____

Address:_____

Individual or Group Insurance Company: _____

Policy Number _____

Yes ☐ I am covered by this policy No ☐ I am not covered by this policy

Social Security or Certificate Number _____

I hereby certify that the foregoing answers I have designated to the stated questions are true complete and correct to the best of my knowledge.

_____

Signature Date Signed

Crafton Hills College Athletic Training
Athlete Supplemental Emergency Information

Full Name:_____

Home address:_____

City/State/Zip_____

Home Number:_____

Cell Number: _____

Student ID: _____

Birthdate:_____

Primary Emergency Contact:

Name:_____

Relation:_____

Address: _____

City/State/Zip:_____

Phone Numbers:

Home:_____

Cell: _____

Work: _____

Secondary Emergency Contact:

Name:_____

Relation:_____

Address: _____

City/State/Zip:_____

Phone Numbers:

Home:_____

Cell: _____

Work: _____

Physician Information:

Primary Physician: _____

Hospital:_____

Phone:_____

Crafton Hills College
Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. A bump, blow or jolt to the head or blow to another part of the body with force transmitted to the head can cause concussions. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You cannot see a concussion and most sports concussions occur without loss of consciousness. Sign and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If you notice signs of a concussion seek medical attention right away.

Symptoms may include one or more of the following:	
• **Headaches** • **"Pressure in the head"** • **Nausea or vomiting** • **Neck pain** • **Balance problems or dizziness** • **Blurred, double or fuzzy vision** • **Sensitivity to light or noise** • **Feeling sluggish or slowed down** • **Amnesia** • **Feeling foggy or groggy** • **Drowsiness**	• **Change in sleep patterns** • **Amnesia** • **"Don't feel right"** • **Fatigue or low energy** • **Sadness** • **Irritability** • **More emotional** • **Confusion concentration or memory problems (forgetting game plays)** • **Repeating the same questions/comment**

Signs observed by teammates, parents and coaches include:	
• **Appears dazed** • **Vacant facial expression** • **Confused by assignment** • **Forgets plays** • **Is unsure of game, score or opponent** • **Moves clumsily or displays incoordination** • **Answers questions slowly** • **Slurred speech**	• **Shows behavior or personality changes** • **Can't recall events prior to hit** • **Can't recall events after hit** • **Seizures or convulsions** • **Any change in typical behavior** • **Loses consciousness**

Crafton Hills College
Student-Athlete Concussion Statement

☐ I understand it is my responsibility to report all injuries and illnesses to my athletic trainer or team physician

☐ I read and understand the concussion fact sheet.

☐ After reading the concussion fact sheet I am aware of the following:

Initials	
	A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.
	A concussion can affect my ability to perform everyday activities and affect reaction time, balance, sleep, and classroom performance.
	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.
	If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.
	I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
	Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before you symptoms resolve.
	In rare cases, repeat concussions can cause permanent brain damage and even death.

_____ _____
Signature of student athlete Date

_____
Printed name of student athlete

_____ _____
Signature of parent or guardian (if athlete under 18) Date

_____
Printed name of parent or guardian

CRAFTON HILLS COLLEGE PRE-PARTICIPATION EXAM PART 1

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the provider. The provider should keep this form in the medical record.)

Name: _____ Sex: _____ Date of birth: _____

Address: _____ City: _____ Zip Code: _____ Sport(s): _____

Medicines and Supplements: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Foods ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you do not know the answers to.

GENERAL QUESTIONS		
1. When was the last complete physical or "checkup?" Date: Month/ Year ____/____ (Ideally, every 12		
	YES	**NO**
2. Has a doctor or other health professional ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical conditions? If so, please identify below.	☐	☐
4. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?	☐	☐
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ___ High blood pressure ___ A heart murmur ___ High cholesterol ___ A heart infection ___ Kawasaki disease Other:_____	☐	☐
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	☐	☐
10. Do you get lightheaded or feel more short of breath than expected, or get tired more quickly than your friends or classmates during exercise?	☐	☐
11. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?	☐	☐
13. Does anyone in your family have a pacemaker, an implanted defibrillator, or heart problems like hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?	☐	☐

BONE AND JOINT QUESTIONS	YES	NO
14. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice, game or an event?	☐	☐
15. Do you have a bone, muscle or joint problem that bothers you?	☐	☐
MEDICAL QUESTIONS	**YES**	**NO**
16. Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
17. Have you ever used an inhaler or taken asthma medicine?	☐	☐
18. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?	☐	☐
19. Do you have any rashes, pressure sores, or other skin problems such as herpes or MRSA skin infection?	☐	☐
20. Have you ever had a head injury or concussion?	☐	☐
21. Have you ever had numbness, tingling, or weakness, or been unable to move your arms or legs after being hit or falling?	☐	☐
22. Have you ever become ill while exercising in the heat?	☐	☐
23. Do you or someone in your family have sickle cell trait or disease?	☐	☐
24. Have you, or do you have any problems with your eyes or vision?	☐	☐
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of food?	☐	☐
28. Have you ever had an eating disorder?	☐	☐
29. Have you ever tested positive or been diagnosed with COVID-19?	☐	☐
FEMALES ONLY	**YES**	**NO**
30. Have you ever had a menstrual period?	☐	☐
31. How old were you when you had your first menstrual period? _____		
32. How many periods have you had in the last 12 months? _____		

Explain "yes" answers here: _____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Date _____

CRAFTON HILLS COLLEGE PRE PARTICIPATION EXAM PART 2: Medical Provider Completes

PHYSICAL EXAMINATION FORM

Name:_____ Sex: _____ Date of Exam: _____

Address: _____ City: _____ Zip Code: _____ Sport(s): _____

EXAMINATION		
Height: Weight: BMI:		
BP: / (/) Pulse: Vision R 20/ L 20/ Corrected ☐ YES ☐ NO		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart •Murmurs (auscultation standing, supine, with and without Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports: _____

Reason: _____

Recommendations: _____

Name of provider (print/type):_____ Date:_____

Phone: _____

Address: _____

Provider/Facility Stamp:

Signature of provider: _____

Reviewed by:_____ (ATC):