



Paradise Valley Community College  
18401 North 32nd Street  
Phoenix, Arizona 85032

Tel 602.787.7173  
Fax 602.787.6715

[www.paradisevalley.edu/athletics](http://www.paradisevalley.edu/athletics)

Dear Paradise Valley Community College Student-Athlete/Parent:

As you may know, participation in athletics here at Paradise Valley Community College requires an annual physical exam and submission of an updated health history form.

Paradise Valley Community College Sports Medicine requires that all student-athletes undergo a physical exam by a medical doctor before being eligible to participate in athletics. We **REQUIRE THAT THIS PHYSICAL INCLUDES AN EKG** and, if necessary, any follow-up testing. Primary health care insurance may provide reimbursement for these tests, so please check with your health insurance provider. This physical must be completed on the PVCC physical form included in this packet.

If a student-athlete attended the free physical held by TOPS on June 11, 2011 there is no need to seek further medical service, unless directed to do so by TOPS. Please confirm that your TOPS physical and EKG are on file with Rick Wade prior to starting any athletic activities with PVCC athletics.

Please feel free to contact us or your coach with any questions or concerns you may have with this physical process. We are happy to provide any additional assistance or resources to help ensure that all PVCC athletes receive the best possible pre-season medical screening.

Sincerely,

*Greg Silcox*

Greg Silcox  
Director of Athletics  
Paradise Valley Community College  
602-787-6622

*Rick Wade*

Rick Wade, MS, ATC/L  
Head Athletic Trainer  
Paradise Valley Community College  
602-787-7167

**PARADISE VALLEY COMMUNITY COLLEGE**  
**HEALTH INSURANCE INFORMATION / AUTHORIZATION**  
**2011-2012**

(PLEASE TYPE OR PRINT IN INK!)

Student-Athlete's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Sex  Male  Female Date of Birth \_\_\_\_\_ Sport \_\_\_\_\_  
 Local Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Policy / ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Insurance Company Phone # \_\_\_\_\_ Type of Insurance-  HMO  PPO  Indemnity  Other

**In case of Emergency, please notify** \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Address \_\_\_\_\_

**Do you have insurance through you, an employer, or a parent/guardian? Yes No**

FATHER'S / GUARDIAN'S INFORMATION	MOTHER'S / GUARDIAN'S INFORMATION
Name _____	Name _____
SS No. _____ DOB _____	SS No. _____ DOB _____
Home Address _____	Home Address _____
Home Phone _____	Home Phone _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Work Phone _____	Work Phone _____
Insurance Company _____	Insurance Company _____
Policy / ID # _____	Policy / ID # _____
Group # _____	Group # _____
Insurance Company Phone # _____	Insurance Company Phone # _____
<u>Type of Insurance-</u> <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity <input type="checkbox"/> Other _____	<u>Type of Insurance-</u> <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity <input type="checkbox"/> Other _____
Primary Care Physician _____	Primary Care Physician _____
Physician Phone # _____	Physician Phone # _____
Is preauthorization necessary for medical/diagnostic services? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone # _____	Is preauthorization necessary for medical/diagnostic services? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone # _____
Is student-athlete covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is student-athlete covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE READ CAREFULLY!**

- ♦ The Maricopa County Community College student accident insurance policy, which provides insurance for student-athletes with *injuries occurring only when participating in the play or practice of intercollegiate athletics*, is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filed with the group insurance company providing coverage. Only after all available benefits have been exhausted will Maricopa County Community College insurance carrier consider payment for any remaining balances. If there is no primary coverage, then our student accident insurance will pay what is considered to be reasonable and customary charges in Maricopa County. If this does not cover the entire bill, then the student athletes is responsible for the remaining balance.
- ♦ I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records to the head athletic trainer at Paradise Valley Community College.
- ♦ I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

**Student-Athlete's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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Dear Health Care Provider,

Participation in athletics at Paradise Valley Community College requires an annual physical exam and submission of an updated health history form. In recent years, an increase of cardiac related deaths while participating in athletics has been noted. As a result, Paradise Valley Community College Athletics **REQUIRES THAT THIS PHYSICAL INCLUDES AN EKG** and, if necessary, any follow-up testing. With your assistance, we are trying to ensure that PVCC athletes receive the best possible pre-season medical screening available. We would appreciate any cooperation you can give with this matter. Thank you for your consideration.

**\*\*PLEASE ATTACH EKG RESULT SHEET TO PHYSICAL WITH A NOTE ON IT CONFIRMING THAT THE EKG IS NORMAL AND THE ATHLETE IS CLEARED TO PLAY.**

Sincerely,

*Rick Wade*

Rick Wade, MS, ATC/L  
Head Athletic Trainer  
Paradise Valley Community College  
18401 N. 32<sup>nd</sup> St.  
Phoenix, Arizona 85032  
602-787-7167

**PARADISE VALLEY COMMUNITY COLLEGE  
STUDENT ATHLETE PRE-PARTICIPATION PHYSICAL EXAM  
2011-2012**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sport(s) \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Vision: **R** 20/\_\_\_\_ **L** 20/\_\_\_\_ Corrected Yes / No

Family history of heart disease? Yes \_\_\_\_ No \_\_\_\_ explain if yes \_\_\_\_\_

Family history of sudden death? Yes \_\_\_\_ No \_\_\_\_ explain if yes \_\_\_\_\_

List any medications you are currently taking. \_\_\_\_\_

List any allergies. \_\_\_\_\_

Date of last tetanus shot. \_\_\_\_\_

EKG (CURRENT EKG REQUIRED) Attach EKG Result Sheet & Clearance				
EKG Date				
MM	DD	YY	<input type="checkbox"/>	Normal
			<input type="checkbox"/>	Abnormal

Previous Injury / Illness	YES	NO	Comments
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elbow Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wrist/Hand Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle/Foot Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine Injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____

	NORMAL	ABNORMAL FINDINGS
Skin	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	_____
Nose	<input type="checkbox"/>	_____
Mouth/Throat	<input type="checkbox"/>	_____
Lymph Nodes	<input type="checkbox"/>	_____
Heart/Cardiovascular	<input type="checkbox"/>	_____
Pulmonary/Lungs	<input type="checkbox"/>	_____
Abdomen/Gastrointestinal	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	_____

**I certify that I have reviewed the history and examined the above student and I recommend:**

**Comments**

- \_\_\_\_\_ Clearance for athletic participation with no limits. \_\_\_\_\_
- \_\_\_\_\_ Clearance pending further evaluation or testing. (Please explain) \_\_\_\_\_
- \_\_\_\_\_ Referral to other health care professional prior to clearance. (Please explain) \_\_\_\_\_
- \_\_\_\_\_ Clearance with limitations. (Please explain) \_\_\_\_\_
- \_\_\_\_\_ Disqualified from competition. (Please explain) \_\_\_\_\_

Provider's signature \_\_\_\_\_ Date \_\_\_\_\_

License Number \_\_\_\_\_ Phone \_\_\_\_\_

**PARADISE VALLEY COMMUNITY COLLEGE**  
**STUDENT ATHLETE HEALTH QUESTIONNAIRE**  
**2011-2012**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sport(s) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Explain all "Yes" answers in space provided below.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you have an ongoing or chronic illness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a rash or hives develop during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever passed out during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been dizzy during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had chest pain during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get tired more quickly than your friends do during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had racing of your heart or skipped heartbeats?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had high blood pressure or high cholesterol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever been told you have a heart murmur?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a severe viral infection (for example, mononucleosis) within the last month?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has a physician ever denied or restricted your participation in sports for any heart problems?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a head injury or concussion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever been knocked out, become unconscious, or lost your memory?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a seizure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have frequent or severe headaches?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had numbness or tingling in your arms, hands, legs, or feet?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever had a stinger, burner, or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you cough, wheeze, or have trouble breathing during or after activity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had heat exhaustion or intolerance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you had any problems with your eyes or vision?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you wear glasses, contacts or protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you want to weigh more or less than you do now?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you lose weight regularly to meet weight requirements or recommendations for your sport?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you feel unusually stressed out?   | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES ONLY**

- |   |       |
|---|-------|
| 30. When was your first menstrual period?                       | _____ |
| 31. When was your most recent menstrual period?                 | _____ |
| 32. How many periods have you had in the last year?             | _____ |
| 33. What was the longest time between periods in the last year? | _____ |

Please comment on any of the "yes" answers. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Signature of Athlete \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Physician Initials