



ATHLETIC DEPARTMENT
3060 WILSON ROAD SW
BIRMINGHAM, AL 35221
205-929-2087

PERSONAL INFORMATION

Date: _____ Sport: _____

Student Name: _____
(include middle name)

Date of Birth: ____ / ____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Cell Phone Number: _____

High School: _____

College: _____

PARENTS OR LEGAL GUARDIAN INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Cell Phone Number: _____

ADDITIONAL EMERGENCY INFORMATION

Name: _____

Telephone Number: _____ Cell Phone Number: _____



EMERGENCY CONTACT & INSURANCE INFORMATION FORM

Name: _____

Date of Birth: ____ / ____ / ____ Sport: _____

SSN: _____ Academic Year: _____

Parents / Guardians Name: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Policy Holder Name: _____ Date of Birth: ____ / ____ / ____

Relationship to Student-Athlete: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Insurance Company Name: _____

Insurance Company Address: _____

Group#: _____ ID#: _____

Effective Date of Policy: ____ / ____ / ____ Expiration Date: ____ / ____ / ____

Primary Physician: _____ Office #: _____

Policy Limit: _____ Policy Deductible: _____ Policy Co-Pay: _____

Does this policy cover athletic-related injuries? _____

I authorize any health care provider, insurance company, person, or organization to release information regarding medical, dental, mental, alcohol, or drug abuse history or treatment or benefits payable, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I further authorize release of this information to LSCC Athletic Department for the purpose of validating and determining benefits payable.

Parent / Guardian Signature Date

Student / Athlete Signature Date

This form must be completed and returned immediately to Mr. Carlton Rice, Athletic Director. You should keep a copy of these documents for your records.

PLEASE ATTACH A COPY (FRONT & BACK) OF YOUR INSURANCE CARD



CONSENT TO PARTICIPATE FOR STUDENT / ATHLETES

I give my permission and understand that the Athletic Trainer, Coaching staff, Team Physician, Administrators, and other school officials can use their own judgement in applying first aid until medical help becomes available, or to secure medical aid and ambulance service in case parents cannot be reached. I voluntarily accept their service on my behalf and grant permission for them to perform their necessary duties as described above.

Name: _____ Date of Birth: ____ / ____ / ____

Phone number to reach parents:

Father: _____

Mother: _____

e-mail: _____

e-mail: _____

Medications currently taking: _____

Known allergies (including medications): _____

Medical conditions (diabetes, epilepsy, etc.): _____

Do you wear contact lenses / glasses? Yes ____ No ____

Any other medically-related conditions that may affect emergency care?

I _____ wish to participate in _____
at Lawson State Community College, Birmingham, AL.

I am aware that the very nature of athletic participation carries with it an inherent risk of injury. I understand that the dangers and risks of participating in athletics, whether in competition or preparing to compete, include but limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all bones, joints ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body and general health and well-being. In addition, I am aware that participation in intercollegiate athletics will involve traveling with the team, and that such traveling any expose me to the risks of a motor vehicle accident, as well as other conditions that result from traveling.

I also accept the responsibility in taking personal measures to help prevent injury to myself or other athletes by notifying the coaching staff, athletic trainer, administrators, or other LSCC personnel of conditions that I am aware of that may predispose me or other athletes to an increased risk of injury resulting from athletic participation.

Having understood the risks of athletic participation and particularly the risk inherent in _____ (sport). ***I voluntarily assume and accept these risks as they have been explained above.***

Student Signature

Date

Parent / Guardian Signature

Date



PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Name: _____ Date: _____
 Address: _____ Date of Birth ___ / ___ / ___
 Age: _____ Sex: _____ Phone: _____
 School: _____ Grade: _____ Sport: _____

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted / denied your participation in sports?		
2. Have you ever been hospitalized or spent a night in a hospital?		
Have you ever had surgery?		
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?		
4. Are you presently taking any medications or pills (prescriptions or over-the-counter)?		
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?		
6. Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain or discomfort in your chest during or after exercise?		
Do you tire more quickly than your friends during exercise?		
Have you ever had high blood pressure?		
Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?		
Have you ever had racing of your heart or skipped heartbeats?		
Has anyone in your family died of heart problems or a sudden death before age 50?		
Does anyone in your family have a heart condition?		
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?		
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?		
8. Have you ever had a head injury or unconscious?		
Have you ever had a seizure?		
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?		
9. Have you ever had heat or muscle cramps?		
Have you ever been dizzy or passed out in the heat?		
10. Do you have trouble breathing or do you cough during or after activity?		
Do you take any medications for asthma (for instance, inhalers)?		

Explain "Yes" answers below:	Yes	No
11. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc.)?		
12. Have you had any problems your eyes or vision?		
Do you wear glasses or contacts or protective eye wear?		
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?		
14. Have you had a medical problem or injury since your last evaluation?		
15. Have you ever been told you have sickle cell trait?		
Has anyone in your family had sickle cell disease or sickle cell trait?		
16. Have you ever sprained / strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ___ Head ___ Back ___ Shoulder ___ Forearm ___ Hand ___ Hip ___ Knee ___ Ankle ___ Neck ___ Chest ___ Elbow ___ Wrist ___ Finger ___ Thigh ___ Shin ___ Foot		
17. When was your first menstrual period? _____ When was your last menstrual period? _____ What was the longest time between your periods last year _____		
Explain "Yes" answers: _____ _____ _____ _____ _____ _____		

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

Signature of Athlete

Date

Signature of Parent / Guardian

Date



PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Height _____ Weight _____ BP _____ / _____ Pulse _____		
Vision R 20 / _____ L 20 / _____ Corrected: ___Yes ___No		
	Normal	Abnormal Findings
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
E.N.T.		
Abdominal		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

Clearance:

A. Cleared

B. Cleared after completing evaluation / rehabilitation for: _____

C. Not cleared for: ___ Collision
 ___ Contact
 ___ Non-contact ___ Strenuous ___ Moderately Strenuous ___ Non-strenuous

Due to: _____

Recommendation: _____

Name of physician: _____ Date: _____

Address: _____ Phone: _____

Signature of physician _____ M.D. or D.O.



NJCAA Eligibility Affidavit

Sport: _____ Date: _____

Fill in all applicable information on this form to assist in determining eligibility for the NJCAA.

Personal Information:

Name: _____ Birth Date: ___ / ___ / ___ ID Number: _____
(First, Middle, Last)

Student's College Address: _____
Street Address City, State, Zip Code

Phone Number(s) at College: _____ Email Address: _____

Other Information:

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

Phone Number: _____ Parent's Name: _____

Foreign Born Students:

Do you have an I-20 Form on file at this college? ___ Yes ___ No

High School Information:

Name of High School(s) you have attended: _____

City, State & Country: _____

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

Were you home schooled? Yes ___ No ___ Did you graduate? **Yes*** ___ No ___

Check here if you have earned a **GED***: ___ GED: Date Earned (month/date/year): ___ / ___ / ___

Did you attend three or more years of high school in the United States? ___ Yes ___ No

*** Enclose a Copy of your High School Transcript, and GED Certificate (if applicable).**

Additional Information:

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

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

* If yes, those transcript(s) from each college must be on file at this college.

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

If yes, specify the College: _____ Date (month/date/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, list the dates of that season, name of college, and describe the situation: _____

(Page 2 - NJCAA Eligibility Affidavit Continued)

5. Have you ever participated in practices, scrimmages, and/or games for an intercollegiate team other than this college? Yes ____ No ____
If yes, name the school, date, sport, and describe the situation: _____
6. Have you ever played on a club team at a college or university? Yes ____ No ____
If yes, name the school, sport, and dates: _____
7. Do you currently play on any other sport teams (i.e. USAV, city recreational leagues, indoor soccer, AAU, etc.)? Yes ____ No ____
If yes, please provide the names of team, location, and dates 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
an included: _____

List ALL Colleges Attended Full-Time and /or Part-Time after High School

All transcripts from all previous institutions must be included.

College: _____ Dates: _____ Full-time ____ Part-time ____

College: _____ Dates: _____ Full-time ____ Part-time ____

College: _____ Dates: _____ Full-time ____ Part-time ____

College: _____ Dates: _____ Full-time ____ Part-time ____

Additional Explanations:

NOTE: If you attended college part-time or were not attending college for any period of time following high school graduation, please document your employment and military history during those times in the space below. If you were unemployed at any time, please list those dates below. The NJCAA requires that you account for any time not enrolled full-time. Please use the space below. Please record months and years when referring to dates. _____

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.

Student-Athlete Signature

Date

Coach Signature

Date

APPENDIX A

ALABAMA COMMUNITY COLLEGE CONFERENCE CONSENT TO DRUG TESTING & ACKNOWLEDGEMENT OF STUDENT-ATHLETE DRUG TESTING POLICY

I certify that I have received a copy of the Alabama Community College Conference Drug Education and Testing Policy for student-athletes, and I have read and understand the requirements of the policy and guidelines in order to participate in intercollegiate athletics, including partial notification requirements.

I understand that to participate in intercollegiate athletics (including athletic managers), I will be required to submit to mandatory drug testing. I agree to submit to specimen collections for purposes of analysis for drug use. I further agree and consent to the disclosure of the records and test results relating to this analysis to be released to ACCC Commissioner, the College's Athletic Director, Head Coach, and college President in order that my eligibility to participate in the athletic program can be determined.

My signature below further authorizes my institution to notify my parents/guardians of the results of my drug test, any sanctions that may or may not be placed on me in relation to the Drug Education and Testing Policy, or other issues relating to the Drug Education and Testing Policy.

Date

Student-athlete's Signature

Witnessed: Coach / Athletic Director

Student-athlete's Printed Name

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

APPENDIX B

SPECIMEN COLLECTION PROCEDURES

A copy of these guidelines must be provided to each collection site person, prior to the collection of the specimen, to ensure that all specimens are collected and tested within these requirements. A specimen collection should not be initiated until the collection site has been made aware of the requirements of these procedures. Collection site personnel should contact the Athletic Director, head coach, or other designated college representative to obtain a copy of these guidelines before any specimen collection is performed.

1. The collection site person shall be a licensed medical professional or technician who has been trained for collection in accordance with chain of custody and control procedures - not a coach, Athletic Director, or any other College employee who is a non-licensed medical professional.
2. Specimen collection procedures shall provide for the designed collection site to be secured in accordance with chain of custody and control procedures. Security during collection may be maintained by effective restriction of access to the collection materials and specimens.
3. When the student-athlete arrives at the collection site, the collection site person shall ensure that the student-athlete is positively identified as the individual selected for testing. This identification can be done through the presentation of photo identification or by an authorized institution representative. If the student-athlete's identity cannot be established, the collection site person shall not proceed with the collection until such identification can be made.
4. If providing a urine sample, the student shall remove any unnecessary outer garments, such as a coat or jacket. The collection site person shall ensure that all personal belongings such as bags, backpacks, purses, etc. remain with the outer garments. Through a visual check, the collection site person will make an effort to ensure that no concealed containers are on the student-athlete's person.
5. Once the specimen has been collected, the student-athlete and the collection site person shall keep the specimen in view at all times prior to its being sealed and labeled. The collection site person and the student-athlete will complete the necessary information on the custody and control form. The student-athlete will sign the custody and control form certifying that the specimen identified as having been collected from him/her is in fact the specimens he/she provided. The specimen and the chain of custody and control form shall then be sealed in a plastic bag and labeled in the presence of the student-athlete. The student-athlete's participation the specimen collection process is complete.



Lawson State Community College

RELEASE OF INFORMATION FORM

In compliance with the Family Educational Rights and Privacy Act (FERPA), the policy of LSCC is to refuse to grant third party access to student records without the written consent of the individual student. Any consent given must include the specific records to be released or reviewed and the names of the individuals to whom the information may be released. If you wish to grant permission for your records to be reviewed, please complete the form below.

Student Name _____ Student # _____

I request the following records be released when appropriate:

___ All of my student records, including athletic information

___ **Academic records**
(transcripts; grade appeals; academic status; advising; Admissions Office files, etc.)

___ **Financial Aid Records**
(including all financial aid applications, awards and files; balances; fines; and Business Office files, etc.)

___ **Disciplinary Records**
(including any disciplinary event or hearing, or other disciplinary action or response)

___ **Other (specify)**

To whom may student files be released?

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Student Signature _____ Date _____



ATHLETIC TRAINING ROOM PRIVACY INFORMATION

Student Athlete Name

Date of Birth

As a participant of Lawson State Community Intercollegiate Athletics Program, I, the undersigned student-athlete do hereby authorize:

- the athletic training staff and the healthcare professionals charged with my care to share my medical information with each other for diagnosis and treatment purposes or with other professionals for educational purposes (i.e. comparison studies about injury/illness)
- the aforementioned persons to release and discuss with my parents and information due to an emergency, illness or injury.
- the aforementioned persons as well as the athletic department's academic staff to release and discuss with my instructors medical information that may affect my class attendance and participation.
- the aforementioned persons to release and discuss with my respective coaches medical information that may affect my participation.
- the aforementioned persons to release and discuss medical information with the NCAA or Southwestern Athletic Conference for the purpose of petitioning for a hardship or exemption.

This authorization applies to all medical records (including prescription information) maintained by Lawson State Community College's Athletic Department, including but not limited to health histories, physician's notes, diagnostic testing results and/or laboratory test results.

I authorize the following regarding payment for services for and medically related service that may affect my athletic participation:

- the athletic training staff and healthcare professionals charged with my care, including their business office and medical records department to utilize, release and discuss any record necessary for the payment of services in which a claim has been filed on my behalf.
- college officials to release and discuss with my primary insurance carrier as well as the college's excess insurance carrier and medical information needed to process such a claim.
- the athletic training staff and other college officials, specifically the athletic department's business office and college's accounts payable department, to utilize, release and discuss such medical information needed to process the payment of services in which the athletic department has authorized

I understand that once the information is disclosed per my authorization, the information is subject to disclose and may longer be protected. I understand that i can revoke this authorization of medical information at my discretion but that authorization cannot be revoked for records already released in reliance upon this authorization. Also, I understand the Athletic Training Staff will provide a copy of this authorization for my records.

This authorization is good for the duration of my association with the Athletic Department of Lawson State Community College or until revocation of the authorization in writing.

Student-Athlete Signature

Date

Parent or Witness Signature

Date



TO ALL STUDENT-ATHLETES:

1. All Athletes must follow the team rules.
2. Athletes are responsible for the expense of the first drug screening.
3. LSCC will not pay for personal items (such as under garments, socks, ankle braces, jocks, sports bras, etc.).
4. All athletes must have medical insurance (school policy does not cover medical emergency, sickness, etc.).
5. All athletes must wear apparels provided by LSCC when traveling and practicing (shoes, uniforms, etc.).

Please sign below to indicate that you agree to and will abide by the above rules.

Athlete Signature

Date