RICHLAND COLLEGE

Dallas County Community College District

Consent for Treatment Form

I. Contact Information

Student's Name_______________________________
Last First MI

Address____________________________________
(Parents) Street , City, State, ZIP

Parents' Names_______________________________

Parents' Home Phone (   ) ____________________

Date_______________ Sport _________________

Age____Birthdate___________Gender_______

SSN_______________ Student ID # ________________

Entering Status: Fr.   So.

Expected year of Graduation______________

Athlete's Cell Phone #: ___________________________

Parent's Email____________________________________

Athlete's Email___________________________________

CONSENT FOR TREATMENT

I give my consent to physicians and Presbyterian Sports Network Sports Medicine Staff to evaluate and treat any injuries that occur during my athletic participation at Dallas County Community College District (DCCCD) events. My consent includes immediate first aid and treatment, physical exams, follow-up, and rehabilitation in the athletic training room as well as at the Student Health Center. I understand that the team physician has the authority to stop me from further participation because of injury and/or because of an undue liability risk to Dallas County Community College District.

I understand that any doctors involved in my care are not employees of Presbyterian Sports Network. I acknowledge that Presbyterian Sports Network is not responsible for the judgment or conduct of doctors who treat or provide a professional service to me.

The Dallas County Community College District athletic accident insurance policy provides some degree of coverage for injuries sustained while participating in the play or practice of intercollegiate athletics. This insurance is excess or secondary coverage over any other available insurance (insurance through parents, employer, etc.). If you are injured a claim must be filed, by you, with all available insurance including this excess accident insurance. The college excess plan will pay subject to a limited schedule and a $100 deductible only after all other available insurance. The Dallas County Community College District is not responsible for payment of any student injury medical expenses regardless of the cause of the injury.

Student-Athlete Signature ____ Date ______________

Parent's Signature (if athlete is under 18 years of age) _____________________ Date ______________

NEXT TWO PAGES TO BE COMPLETED BY THE STUDENT-ATHLETE (OR PARENT IF THE STUDENT IS UNDER AGE 18):

II. Personal History -Please answer all questions. Leave No Blank spaces.

Childhood diseases ____

Do you have any drug allergies? ________ If yes, please list____________________________________

Do you have any food or insect allergies? ________ If yes, please list______________________________

Significant medical conditions (dates & diagnoses) ____

Current medications and reasons for use____

Check boxes to indicate whether you have (or had in the past) these problems. Provide details below.

Y	N		Y	N		Y	N		Y	N	
		Allergies			Gastrointestinal disorder			Lung disease			Heat Illness
		Anemia			Hearing Impairment			Migraine headache			High Cholesterol
		Asthma			Heart disease/murmur			Pneumonia			Sickle Cell Trait
		Bleeding disorder			Hepatitis or liver disease			Psychological problems			Thyroid disorder
		Cancer or malignancy			High blood pressure			Rheumatoid arthritis			Tuberculosis or positive TB test
		Eating Disorder			Infectious Mononucleosis			Rheumatic fever			Visual impairment
		Diabetes			Kidney infection or stone			Seizure disorder			Menstrual Irregularities
											Other

Details____

III. Family History – Check if condition exists in your family (immediate family, grandparents, aunts, uncles)

	Allergies		Cancer		High Blood Pressure		Sudden death		Family history of sudden death before age 50
	Anemia		Diabetes		Lung disease		Tuberculosis		YES NO
	Asthma		Eye disorders		Psychiatric disorders		Ulcer		Please Circle one
	Bleeding disorders		Heart disease		Stroke		Other		

Details____

Have you or a family member been diagnosed with Marfan's Syndrome? **YES NO**

IV. Injury history – Please read and answer all questions!

Have you ever been found to have only one of the following paired organs, and if so, which one is missing?

Eyes	Yes	No	Right	Left
Kidneys	Yes	No	Right	Left
Ovaries	Yes	No	Right	Left
Testicles	Yes	No	Right	Left

1. Do you wear prescribed corrective orthotics? Yes No
2. Do you normally wear eye corrective lenses while participating in sports? Yes No
If yes, do you normally wear… a) glasses? Yes No b) contact lenses? Yes No

Please enclose eye wear prescription

3. Do you have any other medical illness or injury, past or present, that we should know about for your own protection? Yes No

If yes, please explain: ____

Have you had any of the following problems that may have limited your performance and/or caused prolonged pain/discomfort? If **YES**, please provide details below (**date of onset and side, left or right**).

Problem	**Yes**	**No**	**Date of Onset**	**Left**	**Right**	**Explain** (further details at bottom)
Knocked Unconscious						
Concussion						
Neck Injury						
"Burner, Stinger"						
Back Pain						
Shoulder						
Knee						
Ankle						
Foot						
Lower Leg						
Hip						
Elbow						
Wrist						
Arm						
Hand						
Surgery						

Details/Other: ____

V. Physical Examination TO THE LICENSED HEALTH PROFESSIONAL (D.O., M.D., P.A., N.P.)

PERFORMING THIS EVALUATION: Please review the student's health history, and provide additional details as needed. Please complete the physical examination and comment on all positive findings. Height _______ inches Weight ________ lbs. BP __________ Pulse ______ Vision R 20/_____ L 20/_____ **Please record examination findings below. If abnormal, please elaborate**.

	Normal	Abnormal	Explanation		Normal	Abnormal	Explanation
1. HEENT				8. Genitourinary			
2. Eyes				9. Back			
3. Respiratory				10. Extremities			
4. Cardiovascular				11. Skin			
5. Breasts				12. Surgical Scars			
6. Gastrointestinal				13. Endocrine			
7. Hernia				14.Neuropsychiatric			

Physical Examination: Are there any conditions of which we should be aware? Describe fully. Use additional sheet if necessary.

VI. Cardiac History

Family History of Heart Disease Yes No If yes, explain ____
Heart: ____
Lung: ____
Peripheral Pulses: ____

	Yes	No		Yes	No		Yes	No
Shortness of breath			Dyspnea on Exertion			Chest Pain		
Palpations			Dizziness			Syncope		

I have reviewed the information above and make the following recommendations for his/her participation in athletics: _____ Cleared

_____ Not Cleared _____ Cleared – f/u needed (explain below)

F/U Recommendations: ____

Examiner's Signature Street City St Zip

Examiner's Name (PRINTED) Telephone Date