Please read the following information carefully. If you have any questions or do not understand any of the information, please ask the Athletic Trainer before signing.

Explanation of Pre-participation Screening Physical

I realize that the physical examination being done is ONLY a screening type examination to evaluate general health, to disclose existing defects/conditions, and to determine the athlete’s dynamic ability to participate in a given sport, so that obvious conditions, which might be damaged or become aggravated by competitive sports, can be determined and evaluated to prevent injury.

Treatment Consent

I hereby grant permission the team physicians of the San Diego Community College District (SDCCD), and those professional personnel designated by them to treat me. This permission includes emergency surgery and admission to the hospital as deemed necessary, in addition to medications, injections, and physical therapy used as part of the treatment. I/We hereby release the above-named district institutions, its employees and Athletic Trainers, together with all persons assisting with any phase of medical services, from all liability and responsibility in connection with such activities. I/We further agree to indemnify and hold harmless said parties from all claims hereafter made and asserted by or on behalf of the below-named Student-Athlete, their parents, guardian(s), heirs, executors, or assigns.

Awareness of Risk

The responsibility for sport safety must be shared by all, included in this group should be the administrators, coaches, physicians, athletic trainers, and student-athletes. I, the undersigned am aware that there is certain risk of injury involved in my participation in Intercollegiate Athletics. Myself and the San Diego Community College District understand that my signature does, in no way relieve the District of its responsibilities toward my welfare. It is intended to make me aware of the responsibility being shared and that there is a risk of injury. I understand that this includes the risk of spinal cord and brain injury that may result in paralysis and the possibility of other permanent injury or death.

Statement of Athletic Injury Insurance Coverage

I understand that ANY COST for medical expenses incurred as a result of accidental injury while participating in a scheduled intercollegiate activity WILL NOT be paid under the accident insurance policy carried by SDCCD until ALL PAYMENT(S) UNDER ANY EXISTING POLICY COVERING SIAD EXPENSES ARE EXHAUSTED. If no existing insurance policy is in effect, payment will be made according to the schedule of benefits of the SDCCD athletic accident policy. I further understand that FAILURE TO REPORT INJURIES TO THE SAN DIEGO COMMUNITY COLLEGE DISTRICT ATHLETIC MEDICINE PERSONNEL OR TO MEET SCHEDULED PHYSICIAN’S APPOINTMENT(S) may VOID SDCCD’s responsibility and that coverage by SDCCD’s insurance will cover injuries for 52 weeks from the date of original injury only.

I hereby authorize any hospital, trust fund, employer, insurance company, or other person(s) who has attended to me or any dependent, to disclose, when requested to do so by SDCCD’s insurance carrier or team physicians, any or all information with respect to my illness or injury, including, but not limited to, medical history, consultation, prescriptions, treatments, and copies of all hospital or medical records.

I have read all of the above and fully understand its meaning.

________________________________________   ___________________
ATHLETE’S SIGNATURE      DATE