

**NORTHWEST ATHLETIC ASSOCIATION OF COMMUNITY COLLEGE
ATHLETIC QUESTIONNAIRE/RECRUITING DISCLAIMER**

Institution _____ Sport(s) _____ School Year _____

Name _____ SID _____ Date of Birth _____

Home Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Email: _____

High School: _____ (City/State) Date of Grad. _____

If you did not attend college right after high school, please identify what activities and dates you were involved with during that time period:

Date _____ Activity _____

Date _____ Activity _____

Date _____ Activity _____

Have you attended other collegiate institutions, including community colleges, since high school? YES NO

If "YES", list the college and dates (month/year) of enrollment:

Date _____ College _____

Date _____ College _____

If a transfer, state the number of hours transferred. _____ QUARTER HRS. _____ SEMESTER HRS.

Are all official transcripts from all previous colleges attended on file with the Admissions Office? YES NO

ATHLETIC PARTICIPATION: (INCLUDE COMMUNITY COLLEGE):

Have you participated in an intercollegiate contest/event since high school? YES NO

Have you participated in an intercollegiate practice since high school? YES NO

If "YES" to the above, complete the following, listing any participation at all colleges you attended, including present college.

20____ to 20____ _____

20____ to 20____ _____

20____ to 20____ _____

Are you now participating on any other team? YES NO If "YES", name the team _____

When was the last time you participated? _____ Have you notified the team you are leaving? YES NO

LETTER OF INTENT:

Have you ever signed a letter of intent? YES NO If "YES", sport for which letter of intent was signed _____

20____ to 20____ Name of College: _____

AMATEURISM:

Have you ever participated or tried out for a professional team? YES NO

Have you ever played with, received payment or signed a contract to play with a professional team? YES NO

If "YES", list the sport, organization and date signed _____

NWAACC RECRUITING DISCLAIMER

In accordance with Article VI, Section 2 (Athletic Recruiting) of the NWAACC Official Code, the following disclaimer is submitted, specifically, Article VI, Section 2 states: "Athletic recruiting will be confined to only the states of Oregon, Washington, Montana, Alaska, California, Idaho, Nevada and the province of British Columbia. NWAACC grants in aid may be offered or given only to athletes who shall be a high school graduate, or the class year of which they were a member shall have graduated in Washington, Oregon, Alaska, province of British Columbia, California, Idaho, Montana, Nevada and Hawaii. Student-athletes who graduated from a high school or their graduating class outside the aforementioned contiguous states must submit an NWAACC athletic questionnaire to the conference office and complete the following:

1. List reasons for attending NWAACC institution:

2. Why have you moved to Washington, Oregon, or British Columbia:

3. Explain how you found out about the NWAACC institution you wish to attend:

4. List the name of the person you first had contact with at the institution you wish to attend:

5. Please list all financial aid, scholarships, athletic aid, work study, and campus employment, that you have been offered or received by the NWAACC school, as well as the amounts of each award / area (see below)

_____ Federal Financial Aid	Amount Awarded _____
_____ Athletic Aid	Amount Awarded _____
_____ School Scholarship	Amount Awarded _____
_____ Other Scholarships	Amount Awarded _____
_____ Student Loan	Amount Awarded _____
_____ Work Study/FAid	Amount Awarded _____
_____ Campus Job	Amount Awarded _____

6. Date FAFSA Submitted to College Financial Aid Office: _____

****The above financial information verified by Financial Aid Officer:***

Name (Printed): _____ Signature: _____ Date: _____

If you are an international student you must have a signature from the international office, or registrar's office verifying your certificate of finances.

Designated School Official Name: (Printed): _____ Signature: _____ Date: _____

7. Date of initial College Enrollment in any and all credits at College: _____

8. Address that you will be living at while attending this NWAACC member College:

Address: _____ City: _____ State: _____ Zip: _____

Landlord: _____ Phone # of Landlord: _____

Host Family: _____

9. What is your share of the total rent paid per month at the above address: _____

By signing this, I attest that the information I have listed on this questionnaire is accurate and complete. I understand that falsification of my academic, financial aid, housing, and athletic participation records will result in immediate suspension of athletic eligibility in any sport at any NWAACC member college.

Date: _____ (Student-Athlete Printed): _____ Sport: _____
(Student-Athlete Signed): _____ (Designate men or women)

Date: _____ (Head Coach Signed): _____

I agree to provide the NWAACC with any and all information requested to verify eligibility including Housing, Financial Aid, and Academic information.

Date: _____ (Signed): _____

Athletic Director: _____ Coach: _____

College President or Representative: _____

Revised and approved 6/1/12

YOUR LAST PHYSICAL EXAMINATION

Date _____ Doctor's name _____ City, State _____

Please list any abnormalities found on any past physical examinations _____

IMMUNIZATION RECORD

Measles*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____
Mumps*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____
Rubella*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____
Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last dose	_____
Tetanus (Td)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of last shot	_____

*Note: These are commonly noted on immunization records as "MMR" and often given as one shot. A second dose of measles vaccine is recommended for college entrance.

FAMILY MEDICAL HISTORY

Please check YES or NO in appropriate box.

1. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	5. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia
2. <input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	6. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes
3. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuromuscular disease	7. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia
4. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Sudden death from heart disease or stroke	8. <input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer

If living, please check box to signify family member's general health. If deceased, please state age and cause of death, if known.

	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Deceased	Age at Death	Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brother #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

MEDICAL CONDITIONS & ILLNESSES

Have you ever had or do you now have any of the following medical conditions, illnesses or diseases? Please check YES or NO for EACH item.

YES	NO		YES	NO		YES	NO	
9. <input type="checkbox"/>	<input type="checkbox"/>	Polio	26. <input type="checkbox"/>	<input type="checkbox"/>	Recurrent sinusitis	43. <input type="checkbox"/>	<input type="checkbox"/>	Hernia or rupture
10. <input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	27. <input type="checkbox"/>	<input type="checkbox"/>	Hearing loss/ear disease	44. <input type="checkbox"/>	<input type="checkbox"/>	Ulcers
11. <input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	28. <input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease	45. <input type="checkbox"/>	<input type="checkbox"/>	Testicular masses
12. <input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	29. <input type="checkbox"/>	<input type="checkbox"/>	Heart murmur/problems	46. <input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
13. <input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	30. <input type="checkbox"/>	<input type="checkbox"/>	Pericarditis	47. <input type="checkbox"/>	<input type="checkbox"/>	Bleeding disease
14. <input type="checkbox"/>	<input type="checkbox"/>	Collapsed lung	31. <input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	48. <input type="checkbox"/>	<input type="checkbox"/>	Anemia
15. <input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	32. <input type="checkbox"/>	<input type="checkbox"/>	Elevated cholesterol	49. <input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
16. <input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	33. <input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint problems	50. <input type="checkbox"/>	<input type="checkbox"/>	Asthma/hay fever
17. <input type="checkbox"/>	<input type="checkbox"/>	Diabetes	34. <input type="checkbox"/>	<input type="checkbox"/>	Bone infection	51. <input type="checkbox"/>	<input type="checkbox"/>	Skin disease/rash
18. <input type="checkbox"/>	<input type="checkbox"/>	Allergies	35. <input type="checkbox"/>	<input type="checkbox"/>	Chondromalacia	52. <input type="checkbox"/>	<input type="checkbox"/>	Measles
19. <input type="checkbox"/>	<input type="checkbox"/>	Tumors/Cancer	36. <input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	53. <input type="checkbox"/>	<input type="checkbox"/>	Mumps
20. <input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	37. <input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	54. <input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
21. <input type="checkbox"/>	<input type="checkbox"/>	Eye disease	38. <input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	55. <input type="checkbox"/>	<input type="checkbox"/>	Malaria
22. <input type="checkbox"/>	<input type="checkbox"/>	Color blindness	39. <input type="checkbox"/>	<input type="checkbox"/>	Goiter/thyroid disease	56. <input type="checkbox"/>	<input type="checkbox"/>	Car or air sickness
23. <input type="checkbox"/>	<input type="checkbox"/>	Near sightedness	40. <input type="checkbox"/>	<input type="checkbox"/>	Enlarged organs (spleen)	57. <input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown
24. <input type="checkbox"/>	<input type="checkbox"/>	Far sightedness	41. <input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder disease	58. <input type="checkbox"/>	<input type="checkbox"/>	Mental disorder
25. <input type="checkbox"/>	<input type="checkbox"/>	Nasal polyps	42. <input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal bleeding	59. <input type="checkbox"/>	<input type="checkbox"/>	Eating disorder

Student Name _____
 (Last) (First) (Mid. Initial)

Please list all previous fractures, concussions or other head injuries:

Item No.	Physician, City, State	Approx. Date	Injury

Please list all hospitalizations:

Item No.	Physician, City, State	Approx. Date	Reason for hospitalization, length of stay

Describe your current pattern of physical exercise

Activity	Frequency	Duration	Intensity

Describe the sickest you have ever been _____

Describe any weight changes over the last six months _____

List all medications -- prescription and/or over the counter -- drugs or vitamins that you currently take (including aspirin, birth control pills, etc.) _____

Describe any allergies -- from bites, drugs, foods, pollen, etc. -- you may have, including causes and reactions _____

At what age did you have your first menstrual period? _____ How many have you had during the last 12 months? _____

Date of last period _____ Describe any menstrual irregularity or discomfort _____

AGREEMENT OF UNDERSTANDING

I, the undersigned, certify that the above medical history is correct and true to the best of my knowledge, and that this student has no physical defects except as stated. This medical information is given with my permission and the medical examination is taken voluntarily. I further understand that any intentional omission of answers either verbally or in writing may result in disqualification from the community college sports program.

I authorize the release of this medical information, including the medical examination and the results of any medical tests, to the college for their use, evaluation and record keeping for this student-athlete's participation in the sports program of the college. I further authorize the release of this medical information, the medical examination and the results of any medical tests when deemed necessary by the college athletic coach, athletic trainer or other authorized college official; and I grant permission to any hospital, physician, surgeon, or other duly authorized medical personnel to release any other medical records, charts or diagnoses when deemed necessary for the treatment and care of this student-athlete in the event of injury or illness.

I further authorize and request the college's designated medical personnel to administer basic life support, advanced life support, and/or to obtain emergency medical care in the event of injury or illness at any specific emergency care facility so designated by the college physician or representative while participating in the sports program.

By my signature I verify that I have read, understand and agree to the above-stated conditions.

Student _____ Date _____

Parent/Guardian (If student is under 18 years of age) _____

Student Name _____
 (Last) (First) (Mid. Initial)

PHYSICAL EXAMINATION FOR SPORTS PARTICIPATION

To be completed by Licensed Medical Provider

To the Medical Provider: Please obtain and review the student's health history, pages one through four of this form, before conducting the examination. The intent of this exam is to focus on conditions of the athlete that may endanger his/her health, aggravate pre-existing conditions or increase the risk of death from participation in competitive college sports. If your findings or observations during this exam for sports participation indicate a need for a more comprehensive medical examination, you have the option of conducting a more comprehensive exam or advising the athletic director of the college in writing of the need for same. We appreciate your assistance and cooperation in maintaining the health of our student-athletes.

Student Name _____
 (Last) (First) (Middle Initial)

Date of Birth _____ Male Female Height _____ Weight _____
 Month/Day/Year

Blood pressure at rest and sitting: Left arm _____ / _____ mmHG Right arm _____ / _____ mmHG

Resting pulse rate: Apical _____ Radial _____

Visual acuity: Left 20/ _____ Right 20/ _____ Please check appropriate box: With correction Without correction

Please check appropriate box to indicate if Normal or Abnormal, and provide comments if abnormal.

SYSTEM		N	AB	COMMENTS
HEAD	Hair, scalp, masses, injuries			
EYES	Proptosis, conjunctivae, sclera, EOM, pupillary size, reaction to light, peripheral vision, fundi, gross tension to palpation			
EARS	Gross hearing to speech, drums, discharges			
NOSE	Septum, mucosa, sinuses			
THROAT/MOUTH	Teeth, tongue, tonsils, infections, lesions			
NECK	Thyroid, vessels, range of motion, adenopathy, masses, voice abnormalities			
THORAX/LUNGS	Shape, expansion, deformities, rhonchi, wheezes, rales			
HEART	PMI, sounds, thrills, murmurs, gallops, PVCs			
LYMPHATICS	Cervical, axillary			
ABDOMEN	Organ enlargement (liver, spleen, etc.), masses, tenderness, hernias, scars			
GENITALIA	Scrotum, testicles, lesions, discharge, hernias			
RECTAL (Optional)	Hemorrhoids, fissures, prostate, masses			
UPPER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
LOWER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
BACK	Flexion, extension, scoliosis, kyphosis, excessive lordosis, injuries			
NEUROLOGICAL	Cranial nerves, reflexes, motor, gait, balance, sensory			
SKIN	Texture, striae, rash, acne			
MENTAL STATUS	Affect, hostility, agitation			

LABORATORY TESTS (Optional or as indicated by examination)

Urinalysis: Sugar _____ Albumin _____ Keytones _____ Other _____

Hematology: Hematocrit _____

Summary of abnormal lab work _____

If medical history indicates the need for any vaccinations or booster shots, please administer during the physical examination.

Orthopedic Diagnoses _____

General Medical Diagnoses _____

Additional findings or comments on health history/significant injuries or illnesses _____

DISPOSITION (Please check one)

- Unrestricted activity in all sports
- No participation until _____ or until _____
(Date) (Conditions to be met)
- May participate, but with following limitations _____
- May not participate at all for following reasons _____

Medical Provider's signature _____ Date of Exam _____

MEDICAL PROVIDER IDENTIFICATION (Please print. Stamp or label okay)

Name _____ Phone (____) _____

Address _____ City _____ Zip _____

Mail completed form to:

NOTE: The original of this report shall be confidentially filed and maintained in the athletic department. The information shall be readily available to health care providers in event of an emergency when intercollegiate sports are conducted, both at home and away from the college.

Student Name _____
(Last) (First) (Mid. Initial)

INFORMED ACKNOWLEDGEMENT OF HAZARDS AND RISKS CONNECTED WITH PARTICIPATION IN MEN'S SOCCER

THIS FORM MUST BE SIGNED BY THE STUDENT AND PARENT OR LEGAL GUARDIAN IF THE STUDENT IS UNDER 18 YEARS OF AGE. PLEASE READ CAREFULLY AND BE SURE YOU UNDERSTAND BEFORE YOU SIGN.

WARNING

Participation in any athletic activity may involve injury of some type to either yourself or a fellow student athlete. Such injury can include direct physical and possibly crippling injury to one's body. There is also the possibility of suffering emotional distress or psychological injury as a result of witnessing or actually inflicting injury to another. The severity of such injury can range from minor cuts, scrapes, bruises, muscle strains, or bone fractures and dislocations to catastrophic injury, such as complete paralysis, or even death. Such injury can impair one's general physical and mental health and hinder one's future ability to earn a living, to engage in other business, social, and recreational activities, and generally to enjoy life.

MEN'S SOCCER is a competitive ball sport. As in all sports, **MEN'S SOCCER** involves the **RISKS OF SERIOUS INJURY OR DEATH**. Injuries in this sport are common, and occur to all parts of the body, including the head and neck, shoulders, arms, chest, hands and fingers, hips and legs, knees, and ankles and feet. These risks of injury in the sport of **MEN'S SOCCER** include the possibility of: injury to the neck and spinal column or cord, resulting in complete or partial paralysis; injury to the head, resulting in brain damage; and injury to the body's bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system. Injury to the body's nerves, the heart and blood vessels, and other internal or reproductive organs is also possible. Such injuries may cause temporary disability or can result in permanent impairment. Pitchers, in particular, are susceptible to shoulder and arm injuries.

Fatalities in **MEN'S SOCCER** typically are caused by direct blows to the chest from a ball or from head and neck injuries caused by being hit with or by colliding with other players. Pre-existing medical conditions, including illness, disease, and prior injuries can be aggravated or cause other injuries while engaged in the sport of **MEN'S SOCCER**. Use of drugs, alcohol, or medications can contribute to injury or illness while participating in athletic activity. Some injuries may be caused as a result of poor physical conditioning and overexertion. Such overexertion can result in injury to muscles, the heart, and other body parts, resulting in sprains and strains, cardiac or cardiopulmonary arrest, and other medical conditions. **MEN'S SOCCER** injuries can also result from the use of correct or incorrect playing techniques used in tryouts, practices, warm-ups, drills, games, plays, or other similar undertakings. Injury to the head or other parts of the body can result from contact with other participants, the playing surface, training equipment, the backstop, and other solid objects in and around the playing field. Injury can result from the improper fit of equipment, from defective or worn-out equipment, and from otherwise wearing and/or failing to use **MEN'S SOCCER** equipment or other protective gear. Injury can result from training room procedures; from the use of training equipment; from the administration of first aid; or from failing to follow game, training, safety or other team rules. The use of transportation provided or arranged by the College to and from **MEN'S SOCCER** games and other related activities also involves a risk of injury or death.

The purpose of this WARNING is to bring your attention to the existence of potential dangers associated with athletic participation. There is, however, always the risk of other types of injuries or the risk of injury or death resulting from other causes not specified here.

The purpose of this WARNING is also to aid you in making an informed decision as to whether you (or your child or ward) should participate in this athletic activity and, as a condition of such participation, sign the foregoing **ACKNOWLEDGEMENT OF HAZARDS AND RISKS CONNECTED WITH PARTICIPATION IN MEN'S SOCCER**. In addition, its purpose is to make you aware that as a student-athlete (or as a parent or guardian of a student-athlete), it is your responsibility to learn about and/or ask coaches, physicians, or other knowledgeable persons about any concerns that you might have at any time regarding athletic safety and participation in the community college's **MEN'S SOCCER** program. **STUDENT-PARENTAL**

ACKNOWLEDGEMENT OF HAZARDS AND RISKS I have read the above warning, which is incorporated here by reference, and I understand that **MEN'S SOCCER** is a sport involving the **RISKS OF INJURY OR DEATH**. I also understand that by participating (or by permitting my child or ward to participate) in the **MEN'S SOCCER** program at this community college, I (my child or ward) am subject to the possibility of injury or death as outlined in the **WARNING** above. **CAUTION BY SIGNING THIS ACKNOWLEDGEMENT OF HAZARDS AND RISKS, I ACKNOWLEDGE THAT I HAVE READ ITS CONTENTS AND WARNING, THAT I UNDERSTAND ITS CONTENTS AND WARNING, AND THAT I AGREE TO ITS TERMS AND CHOOSE TO PARTICIPATE (OR TO PERMIT MY CHILD OR WARD TO PARTICIPATE) IN THE INTERSCHOLASTIC SPORTS OF MEN'S SOCCER AT THIS COMMUNITY COLLEGE.**

Date: _____ Signature of Student: _____

*Signature of Parent or Legal Guardian (if student is under 18 years of age) _____

WITNESS – COLLEGE OFFICIAL

On the _____ day of _____, 20 _____, I witnessed the execution of the above.

Signature of School Official Position

*NOTE: If it is not possible for a college official to witness the signature of the parent or legal guardian when the student is under the age of 18, a notary shall witness the parent's or guardian's signature to this acknowledgement of hazards and risks.