Cisco College – Department of Sports Medicine 2018-2019 Student-Athlete Medical Packet

Cisco College
Department of Sports Medicine
101 College Heights
Cisco, TX 76437
Facility Main Number: (254) 442-5195

Michael L. Garcia, LAT – Athletic Trainer
Office Phone: (254) 442-5064 Email: michael.garcia@cisco.edu
College Fax: (254) 442-5100
Please address all faxes with :
Attention: Michael Garcia

Dear Student-Athletes (and Parents),

The Department of Sports Medicine is pleased to have you as a student-athlete at Cisco College and we wish you nothing but success both academically and athletically during your time with us! Enclosed with this letter are the pre-participation medical information forms needed to participate in athletics at Cisco College. Please thoroughly read and complete the enclosed paperwork. Athletes are required to return the completed forms to the Cisco College Department of Sports Medicine at the time of/or prior to their team's first meeting/practice.

YOU WILL NOT BE PERMITTED TO PARTICIPATE UNTIL ALL INFORMATION FROM THIS PACKET HAS BEEN RECEIVED AND YOU HAVE BEEN MEDICALLY CLEARED BY A PHYSICIAN.

Please pay careful attention to the following key policies when reviewing this packet:

- In accordance with NJCAA regulations, all prospective student-athletes must receive medical clearance (in the form of a Pre-Participation Physical) from a physician prior to participation in any intercollegiate sport activity (tryouts, practice, workouts, etc.).
  Each year, Cisco College Department of Sports Medicine requires ALL student-athletes to provide a valid pre-participation physical exam that meets NJCAA standards. A physician(s) has
- the final authority to medically clear a student-athlete for participation. Your personal health
- insurance is primary for all costs related to intercollegiate athletic injuries. The medical
- information requested by the Cisco College Department of Sports Medicine is in addition to, and not in place of, medical information requested of all students by Cisco College Admissions Office, Financial Aid Office, and/or Housing Department. Cisoc College also follows the Affordable Healthcare Act of everyone MUST have insurance, therefore ALL student athletes are required to have primary Helath insurance that includes an sports related accident coverage.

The Cisco College Department of Sports Medicine serves and supports each student-athlete, and Cisco College as a whole, by working collaboratively with a variety of health care professionals. Together, we provide the most comprehensive and evidence based healthcare practices, while maintaining the highest level of professionalism and integrity.

Should you have any questions please contact the Department of Sports Medicine at (254) 442-5198 for mens team sports or (254) 442-5064 for womens team sports.

Sincerely,
The Cisco Collge Department of Sports Medicine

Cisco College – Department of Sports Medicine

2018-2019 Student-Athlete Medical Packet Checklist

The following checklist is intended to assist you with completion of your medical packet. **ALL** of the following must be completed prior to returning the medical packet. Failure to do so will result in an incomplete sports medicine packet and the student-athlete **WILL NOT** be permitted to participate in intercollegiate athletics at Cisco College.

☐ Student-Athlete Information Form

☐ Insurance Information Form

☐ Insurance Card Copy (front and back of card required)

☐ Student-Athlete Medical History Information Form (3 pages)

☐ Pre-Participation Physical Examination Form (bottom section to be completed during physical exam by a physician)

☐ Notice of Privacy Practices – Student-Athlete Authorization/Consent for Disclosure of PHI Form

☐ Drug Abuse Education/Screening Program – Drug Test Informed Consent

Should you have any questions please contact the Department of Sports Medicine at (254) 442-5064 for mens team sports or (254) 442-5064 for womens team sports.

2018-2019

Cisco College – STUDENT-ATHLETE INFORMATION

(Please write legibly using blue or black ink)

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ (MM/DD/YY)

SS #: ___ - ___ - ___ SID #: _____ Clinic #: _____

Sport: _____ ☐ Freshman ☐ Sophomore ☐ Red Shirt Freshman ☐ Red Shirt Sophomore

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Temporary (On Campus) Address: _____

_____ _____ _____

City *State* *Zip Code*

Permanent (Off Campus) Address: _____

_____ _____ _____

City *State* *Zip Code*

Student-Athlete Cell Phone: _____ Student-Athlete Alternate Phone: _____

Student-Athlete Email Address: _____

EMERGENCY CONTACTS

Primary Contact: _____ Relationship to Student-Athlete: _____

_____ _____

Cell Phone # *Alternate Phone #*

Secondary Contact: _____ Relationship to Student-Athlete: _____

_____ _____

Cell Phone # *Alternate Phone #*

In an emergency, I authorize the Cisco College Department of Sports Medicine and affiliated providers to contact the person(s) listed above.

Student-Athlete's Signature _____ **Date** _____

MANDATORY

INSURANCE INFORMATION FORM

Athlete's Name: _____ Athlete DOB: _____ SS #: _____

Permanent Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

POLICY HOLDER'S INFORMATION *(policy holder/subscriber may not be the student-athlete)*

Subscriber: _____ Subscriber's DOB: _____ SS#: _____

Home Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

Cell Phone: _____ Home Phone: _____

Employer: _____

Employer Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

Insurance Company: _____ Insurance Company Phone #: _____

Insurance Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

Policy/ID#: _____ Group #: _____

Type of Insurance: ☐ HMO ☐ PPO ☐ Indemnity ☐ Other _____ Does this policy include dental coverage? ☐ YES ☐ NO

Primary Care Physician: _____ Physician Phone #: _____

Please Check One:

☐ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by my son/daughter.

☐ My son/daughter is NOT covered under my group insurance / or ANY OTHER INSURANCE AT THIS TIME! MUST CONTACT BEVERLY MASSEY @254-442-5516

PLEASE READ CAREFULLY

- I hereby authorize the Cisco College Department of Intercollegiate Athletics, hospitals & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I agree to supply any & all information requested by my primary insurance, the Cisco College Department of Intercollegiate Athletics & their excess insurance company in a timely manner.
- I hereby authorize the Cisco College Department of Intercollegiate Athletics and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.
- I hereby authorize the Cisco College Department of Sports Medicine and/or my coach to hospitalize & secure treatment for me for any athletic injury/ illness.
- A photocopy of this authorization shall be deemed as effective & valid as the original.
- I agree to notify the Cisco College Department of Sports Medicine immediately upon any change in the above health insurance information. Should I fail to do so, I fully understand that I may be responsible for any & all charges incurred.
- 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. It is illegal to knowingly provide false information on this form.

In the absence of the policy holder's signature, the signature of the covered student-athlete will be acceptable.

Student-Athlete's Signature _____ **Date** _____

Policy Holder's Signature _____ **Date** _____

INSURANCE CARD

Athlete's Name: _____ DOB: _____ Sport: _____

Copy **FRONT** of insurance card below

Copy **BACK** of insurance card below

Athlete will not be medically cleared to participate without legible copy of front and back of insurance card

****Should you choose not to use this exact page to provide a copy of your insurance card, please follow the above format including the student-athlete's name, date of birth and sport at the top of the page****

Cisco College Sports Medicine – Athletics Insurance Information

The Cisco College Department of Sports Medicine provides outstanding medical care to all student-athletes. Following an injury sustained during intercollegiate participation, the student-athlete will be cared for in the Cisco College athletic training room or affiliated hospital/clinic. The Cisco College team physicians and all affiliated providers have the final authority to medically clear a student-athlete for return to participation. When a student-athlete must be seen outside the Cisco College athletic training room for services, such as office visits, MRI, surgery, X-rays, tests, dental, etc., additional charges are incurred.

Most employers' group insurance allows dependent coverage to be continued to age 25 if the dependent is a full time student. DO NOT drop dependent coverage while your son/daughter is participating in intercollegiate athletics. All student-athletes must provide current primary insurance information that includes coveragae for athletic/sports related injuries & illness before they will be allowed to participate in their sport. All student-athletes are responsible for payment of athletic/sports related injuries & illness once both primary and secondary insurance has paid out their portions of medical expenses.

I understand it is my responsibility to provide primary medical insurance on myself to participate in any Intercollegiate activity/ or Performing Arts at Cisco College. I must maintain this insuracne throughout my status as a participant of a group of Cisco College. If I do not have primary insurance I will enroll in one of the following and provide proof of insurance to Cisco College before being allowed to begin practice or participate.

1.) http://www.hhs.gov/healthcare (Must sign during open enrollment period)

2.) Allied National Short-term medical plan: http://tempmedsales.alliednational.com/?affiliate=29759

We, Cisco College, **DO NOT** have the option of waiving the requirement of filing with the student-athlete's group insurance.

The Cisco College Athletics secondary insurance policy will only be filed on once the primary insurance of the student-athlete has been filed on and has paid its portion of medical expenses that have incurred.

In most instances, providers utilize a single billing address. Therefore, invoices will often be sent to the student-athlete's or the parent's/guardian's address rather than to the Cisco College Department of Sports Medicine. If invoices are sent to the parent's/guardian's address they should NOT be ignored. Please submit these invoices to your medical insurance company. Any athletically related charge not covered by your medical insurance can then be sent, along with an explanation of benefits and/or full itemized invoice to the Cisco College Department of Sports Medicine at:

Cisco College
Department of Sports Medicine
101 College Heights
Cisco, TX 76437

If a student-athlete visits a medical provider/facility without a referral from the Cisco College Sports Medicine Department, the student-athlete will be responsible for all charges incurred. If a student-athlete elects NOT to utilize the Cisco College Department of Sports Medicine or its networks of physicians for services/surgery, the student-athlete will be responsible for all charges incurred, unless prior approval is obtained from the Cisco College Department of Sports Medicine or team physician in writing.

*****Please keep this page for your records*****

2018-2019

STUDENT-ATHLETE MEDICAL HISTORY INFORMATION FORM

Athlete's Name: _____ DOB: _____ Sport: _____

1. Please answer the following questions to the best of your knowledge. (Additional pages may be added as necessary)

		Circle		If YES, please explain below.
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	YES	NO	
2.	Do you have an ongoing medical condition? (ex. Diabetes, Asthma, ADD, ADHD, etc.)	YES	NO	
3.	Are you currently ill in any way?	YES	NO	
4.	Do you currently have any injuries that are not completely healed?	YES	NO	
5.	Have you been hospitalized overnight for any illness or injury?	YES	NO	
6.	Have you had surgery?	YES	NO	
7.	Have you passed out or become dizzy DURING or AFTER exercise?	YES	NO	
8.	Have you had pain, discomfor, or pressure in your chest during or after exercise?	YES	NO	
9.	Do you tire more quickly than your friends/teammates during exercise?	YES	NO	
10.	Have you ever had a high blood pressure reading?	YES	NO	
11.	Have you ever been told that you have a heart murmur?	YES	NO	
12.	Have you had racing of your heart or skipped heartbeats?	YES	NO	
13.	Do you suffer from shortness of breath or wheezing during exercise?	YES	NO	
14.	Do you have any rashes, pressure sores or other skin problems?	YES	NO	
15.	Have you been diagnosed with a concussion?	YES	NO	
16.	Haver you been knocked out or unconcious?	YES	NO	
17.	Have you had a seziure?	YES	NO	
18.	Have you had a stinger, burner, or pinched nerve?	YES	NO	
19.	Have you been dizzy or passed out from the heat?	YES	NO	
20.	Have you had heat illness or muscle cramps?	YES	NO	
21.	Have you had problems with your eyes or vision?	YES	NO	
22.	Do you wear glasses, contacts or protective eyewear?	YES	NO	
23.	Do you use any special equipment? (pads, braces, mouth guards, etc.)	YES	NO	
24.	Have you had any significant medical illnesses (mono, pneumonia, etc.) in the last year?	YES	NO	
25.	Have you gained or lost 10+ lb in the last year?	YES	NO	
26.	When was your most recent tetanus shot?	XXX	XXX	
27.	Any other acute or chronic injuries, illnesses, or conditions not mentioned above?	YES	NO	
28.	Do you have any medical concerns that you wish to speak to a doctor about?	YES	NO	

By signing below, I certify that all answers above are correct and true to the best of my knowledge.

Student-Athlete's Signature _____ **Date** _____

2018-2019

STUDENT-ATHLETE MEDICAL HISTORY INFORMATION FORM

Athlete's Name: _____ DOB: _____ Sport: _____

2. Have **you** sprained, strained, dislocated, fractured, had repeated swelling or other injuries of ANY bones or joints?

	Circle		If YES, please explain below.
Head/Neck	YES	NO	
Back	YES	NO	
Shoulder	YES	NO	
Elbow	YES	NO	
Wrist/Hand	YES	NO	
Hip	YES	NO	
Knee	YES	NO	
Ankle/Foot	YES	NO	
Other	YES	NO	

3. Have **you** ever had or been diagnosed with any of the following?

	Circle		If YES, please explain below.
Anemia	YES	NO	
Asthma	YES	NO	
Diabetes	YES	NO	
Hearing Problems	YES	NO	
Hepatitis	YES	NO	
Hernia	YES	NO	
Migraines	YES	NO	
Mononucleosis	YES	NO	
Theumatic Fever	YES	NO	
Tuberculosis	YES	NO	
Ulcers	YES	NO	
Other	YES	NO	

4. Do **you** have allergies to any of the following?

	Circle		If YES, please list below.
Food	YES	NO	
Medication	YES	NO	
Animal (Bite/Sting)	YES	NO	
Latex	YES	NO	
Other	YES	NO	

5. List **ALL** over-the-counter and prescription medications and/or supplements you are **CURRENTLY TAKING** and/or **HAVE TAKEN** in the **PAST 18 MONTHS**. (Additional pages may be added as necessary)

	Substance	Dosage	Dates/Length of Time Taken	Purpose
1.				
2.				
3.				

By signing below, I certify that all answers above are correct and true to the best of my knowledge.

Student-Athlete's Signature _____ **Date** _____

2018-2019

STUDENT-ATHLETE MEDICAL HISTORY INFORMATION FORM

Athlete's Name: _____ DOB: _____ Sport: _____

6. **FEMALES ONLY** – (Males skip to section 7)

		Circle		Please add comments below as necessary
1.	Are you happy with your current weight?	YES	NO	
2.	Are you trying to gain or lose weight?	YES	NO	
3.	Has anyone recommended that you change your weight or eating habits?	YES	NO	
4.	Do you limit or carefully control what you eat?	YES	NO	
5.	Are you a vegitarian?	YES	NO	
6.	Are you or have you experienced an irregular menstral cycle?	YES	NO	
7.	At what age was your first menstrual cycle?	N/A	N/A	
8.	Have you missed any cycles within the past 12 months?	YES	NO	If yes, what is the longest you've gone between periods?
9.	How many menstrual cycles total have you had in the past 12 months?	N/A	N/A	
10.	Are you on birth control or other hormonal medication?	YES	NO	If yes, ensure medication is listed in section 5 on previous page
11.	Are you currently pregnant?	YES	NO	
12.	Have you ever been pregnant?	YES	NO	
13.	Do you have a history of stress fractures?	YES	NO	
14.	Do you have any medical concerns that you wish to speak to a doctor about?	YES	NO	

7. Has any **blood relative** ever had or been diagnosed with the following?

	Circle		If yes, please idicate who (i.e. paternal grandmother, etc.)
Blood Disease (sickle cell, leukemia, etc.)	YES	NO	
Diabetes	YES	NO	
Epiplepsy	YES	NO	
Gout	YES	NO	
Heart Disease (including heart attack)	YES	NO	
Hemophilia	YES	NO	
High Blood Presure	YES	NO	
Marfan's Syndrom	YES	NO	
Sudden Death (before age 55)	YES	NO	

By signing below, I certify that all answers above are correct and true to the best of my knowledge.

Student-Athlete's Signature _____ **Date** _____

2018-2019
PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SID #: _____ Clinic #: _____

Sport: _____ ☐ Freshman ☐ Sophomore ☐ Red Shirt Freshman ☐ Red Shirt Sophomore

ATHLETES PLEASE DO NOT WRITE BELOW THIS LINE. MEDICAL PERSONNEL STAFF ONLY

Height: _____ inches Weight: _____ lbs BP: _____ / _____ Pulse: _____ bpm

Vision: (R) ____ / ____ (L) ____ / ____ (Both) ____ / ____ Corrected? ☐ YES ☐ NO

	Normal	Abnormal	Comments
Medical			
HEENT			
Pulmonary			
Heart			
Pulses			
Abdominal			
Skin			
Other			
Orthopedic			
Head/Neck			
Back			
Shoulder			
Elbow			
Wrist/Hand			
Hip			
Knee			
Ankle			
Foot			
Other			

CLEARED **NOT CLEARED** **CLEARANCE PENDING** (comments below)

Comments: _____

_____

_____

Physician's Signature _____ **Date** _____

Cisco College Sports Medicine – Notice of Privacy Practices

A. WE HAVE A LEAGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We, the Cisco College Department of Sports Medicine and affiliated providers, are required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI." We must give you notice of our legal duties and privacy practices concerning PHI:

- We must protect PHI that we have created or received about: your past, present, or future health condition; health care we provide to you; or payment of your health care.
- We must notify you about how we protect your PHI.
- We must explain how, when and why we use and/or disclose your PHI.
- We may only use and/or disclose PHI as we have described in this notice.

This notice describes the types of uses and disclosures that we may make. In addition, we may make other uses and disclosures, which occur as a byproduct of the permitted uses and disclosures described in this notice. If we participate in an "organized health care arrangement" (described in subsection B.3), the providers participating in the "organized health care agreement" will share PHI with each other, as necessary, to carry out treatment, payment or "health care operations" (described in subsection B.3) relating to the "organized health care agreement."

We are required to follow the procedures in this notice. We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that we maintain. All athletes will be notified of changes as they occur.

B. WE MAY USE AND DISCLOSE PHI ABOUT YOU WITHOUT YOUR AUTHORIZATION IN THE FOLLOWING CIRCUMSTANCES

1. We may use and disclose PHI about you to provide <u>health care treatment to you</u>.

We, the Cisco College Department of Sports Medicine and affiliated providers, may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, x-ray and/or other health services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

2. We may use and disclose PHI about you to <u>obtain payment for services</u>.

We may use and give your medical information to others to bill and/or collect payment for the treatment and services provided to you by us or by another provider. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan/policy and for approval of payment before we provide the services. We may also share portions of medical information about you with the following:

- Billing departments
- Insurance company or companies associated with the Cisco College Athletic Department
- Collection departments or agencies, or attorneys assisting us with collections
- Insurance companies, health plans and their agents, which provide you coverage
- Hospital departments that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury
- Consumer reporting agencies (e.g. credit bureaus)

3. We may use and disclose PHI about you for <u>health care operations</u>.

We may use and disclose PHI in performing business activities, which we can call "health care operations." These "health care operations" allow us to improve the quality of care we provide and reduce health care cost. We may use also disclosed PHI for the "health care operations" of any "organized health care arrangement" in which we participate. An example of an "organized health care arrangement" is the care provided by a hospital and the physicians who see patients at the hospital. In addition, we may disclose PHI about you for the "health care operations" of other providers involved in your care to improve the quality, efficiency and/or cost of their care or to evaluate and improve the performance of their providers.

4. **We may use and disclose PHI under circumstances <u>without your authorization or an opportunity to agree or object</u>.**

   We may use/or disclose PHI about you for a number of circumstances, in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

   - When the use and/or disclosure is required by law
   - When the use and/or disclosure is necessary for public health activities
   - When the disclosure relates to victims of abuse, neglect or domestic violence
   - When the use and/or disclosure is for health oversight activities
   - When the disclosure is for judicial and administrative proceedings
   - When the disclosure is for law enforcement proceedings
   - When the use and/or disclosure relates to organ, eye, or tissue donation purposes
   - When the use and/or disclosure relates to medical research
   - When the use and/or disclosure is to avert a serious threat to health or safety
   - When the use and/or disclosure relates to specialized government functions
   - When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations

5. **You can object to certain uses or disclosures.**

By signing the Notice of Privacy Practices, we may use or disclose PHI about you in the following circumstances:

- We may share any injury or illness condition with coaches in your sport that directly affects your participation in that sport
- We may share any injury or illness condition with athletic department administration that includes health risks, drug testing, payment of services, etc.
- We may share any injury or illness condition with the athletic department's sports information director and/or media outlets upon approval by the head coach of your sport
- We may share any injury or illness condition with your parents or guardians
- We may share any past or present injury or illness condition with university scouts

**** ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION****

Under any circumstances other than those listed above, we will ask for your written authorization before using or disclosing PHI about you. If you sign a written authorization allowing us to disclose PHI about you, with regards to a specific situation, you may later cancel your authorization in writing by contacting the Cisco College Department of Sports Medicine. You reserve the right to cancel any portion of your written authorization for disclosure of PHI. Cancellation must come in written form clearly explaining your decision. Written cancellation must be signed and dated and returned to the Cisco College Department of Sports Medicine. A revocation is not effective to the extent at which action has already been taken in reliance on this authorization/consent. If you cancel your authorization in writing we will not disclose PHI about you after we receive your cancellation, except for disclosures, which were being processed before your cancellation was received.

Cisco College Sports Medicine – Notice of Privacy Practices

STUDENT-ATHLETE AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____, hereby authorize the Cisco College and its Sports Medicine
Athlete's Name (printed)
Department, athletic department personnel, physicians, conference, and other associated health care personnel/providers the right to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics.

I have read and understand completely the Cisco College Sports Medicine Notice Of Privacy Practices. I understand that my injury/illness information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) and is not to be disclosed without my authorization under HIPAA. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment of payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization/consent in order to be eligible for participation in NJCAA or conference athletics.

This authorization/consent expires six (6) years from the date at which it is signed, and I have the right to revoke it or any portion of it at any time by delivering in person or by mail a signed written notification to the Cisco College Sports Medicine Department located at:

Cisco College
Department of Sports Medicine
101 College Heights
Cisco, TX 76437

I understand that a revocation is not effective to the extent in which action has already been taken in reliance on this authorization/consent.

Athlete's Last Name: _____ Athlete's First Name: _____ MI: ___

Date of Birth: _____ SS #: _____ Clinic #: _____

Sport: _____ ☐ Freshman ☐ Sophomore ☐ Red Shirt Freshman ☐ Red Shirt Sophomore

Athlete's Signature _____ **Date** _____

I/We as parent(s) or guardian(s) agree.

Parent/Legal Guardian's Signature _____ **Date** _____
(Sign only if athlete is under 18 years of age)

Drug Abuse Education/Screening Program

The Cisco College Department of Athletics requires a thorough medical examination for all student-athletes each year. Included in this examination is a drug-screening test should the Cisco College Department of Athletics deem it necessary. The drug-screening program is being provided for the benefit of the student-athlete. It has the following objectives: to educate the student-athlete about the dangers of drug abuse, to deter drug abuse within the athletic community, to maintain the integrity of the athletics program and eliminate any embarrassments to the student-athlete, their family and the college as a whole.

The **Informed Consent Form MUST** be signed by each student-athlete prior to drug screening. The consent will indicate the student-athlete understands the program, its purpose, method, and subsequent enforcement procedures for a positive test result; and release of test results to limited athletics personnel. Any student-athlete refusing a drug screening **WILL NOT** participate in practice or competition.

Protocol for Specimen Collection

If a student-athlete is chose for a specimen collection, the following steps will occur:

1. A member of the sports medicine department will have the student-athlete choose a collection kit.
2. The student-athlete will open the collection kit, remove the specimen cup and give the other material to the athletic trainer.
3. The student-athlete will take the collection cup to a secure area for a fully witnessed collection of specimen. Witnesses will be members of the sports medicine staff of the same gender.
4. The athletic trainer will have the student-athlete provide the collection of specimen in the collection cup, close tightly and place a security label across the enclosing lid.The student athlete will witness the athletic trainer sealing off their specimen collected.
5. The student-athlete will then sign his/her collection papers.
6. The athletic trainer will hold the collection for results of on-site drug test screening. All positive screenings will be packaged with collection papers to confirm positive results.
7. An independent laboratory personnel will analyze shipped specimen for further testing.

Reaction to Positive Test

The independent laboratory will send test results/reports to the Cisco College Sports Medicine Department for review with the team head coach and athletic director. When a test is deemed positive, the laboratory will verify the positive results by producing an analytical breakdown of the specimen provided.

Following confirmation of a student-athlete's positive test result, the athletic director and the student-athlete's head coach will confer to determine possible sanctions to be imposed. Possible sanctions include, but are not limited to, counseling and re-testing, team demotion or other limitations on participation, suspension, dismissal, and non-renewal of financial aid.

Frequency of Drug Screening

The Cisco College Sports Medicine Department determines when drug screening will take place. The head coach of a team (or random individuals) will be notified the day prior to testing in order to set-up a "meeting time" for the student-athletes. The student-athletes will not be informed prior to a drug screening.

Confidentiality

The Department of Intercollegiate Athletics will ensure, to the best of its abilities, the integrity in the program and confidential results and counseling of the student-athletes. There is also a responsibility of the student-athlete to maintain the same confidentiality.

Drug Abuse Education/Screening Program – Drug Test Informed Consent

I _____, have read and understand the information pertaining to the Drug Abuse
Athlete's Name (printed)
Education/Screening Program within the Cisco College Department of Intercollegiate Athletics. Should I show a positive result, the program's objectives, method of sampling and subsequent policy of enforcement have been clearly defined. I understand that all results of the screening will be keep confidential to the best of the Cisco Colleges' ability according to the described procedure. I, therefore, fully consent to participate in the program, undergo all the required tests, and cooperate in its administration. In consideration of participation in the Intercollegiate Athletic Program, I release Cisco College, the Department of Sports Medicine, and its employees from any and all liability and waive any and all claims against Cisco College and the Department of Sports Medicine arising out of the Drug Abuse Education/Screening Program, unless such claim is base on negligent or wrongful conduct of Cisco College, the Department of Sports Medicine and its employees.

Athlete's Signature _____ **Date** _____

I/We as parent(s) or guardian(s) agree.

Parent/Legal Guardian's Signature _____ **Date** _____
(Sign only if athlete is under 18 years of age)