College Connection Showcases: 2025 HEALTH FORM

CC HEALTH FORM MUST BE HAND-CARRIED TO CHECK-IN

** If you wish to supply a valid 2024 – 2025 signed school health/sports physical form, please complete the contact information below and sign/date the CC Form by both player and parent/guardian.

STAPLE SCHOOL FORM to back of CC form and HAND CARRY to Check IN.

Last Name_____ First Name_____ DOB_____

Insurance Company:_____ Membership Number:_____

Emergency Contact: _____ Cell Phone Number: _____

Applicant has had (please provide dates below or attach separate sheet)

DISEASE	VACCINATION	IMMUNIZATION
Measles		
Hepatitis B (for children born after 1/1/92)		
Mumps		
Whooping Cough		
Chicken Pox		
Tetanus		
Diphtheria		
Polio		
TB Test		

PLEASE CHECK ANY OF THE APPLICANT'S HEALTH PROBLEMS IN THE PAST OR PRESENT AND GIVE THE YEAR. Have you ever had, or now have, any of the following?

General	Yes	No	Briefly Explain
Asthma			
Tuberculosis			
Polio			
Diabetes			
Allergies:			
Medications			
Food			
Bee Stings			
Fungus			
Herpes			
Staph (Boils)			
Cyst or Lumps			
Spleen Injury			
Contact Lenses			

Are you currently taking any medications, prescribed or otherwise? _____Yes _____No

If yes, please explain: _____

Neurological	**Yes**	**No**	**Briefly Explain**
Head Injury:	____	____	_____
Concussion	____	____	_____
Nose Fracture	____	____	_____
Neck Injury	____	____	_____
Heat Problems	____	____	_____

Cardiopulmonary	**Yes**	**No**	**Briefly Explain**
Chest Pains	____	____	_____
Palpitations	____	____	_____
Shortness of Breath	____	____	_____
High Blood Pressure	____	____	_____
Heart Murmur	____	____	_____
Fainting	____	____	_____

Orthopedic	**Yes**	**No**	**Briefly Explain**
Foot/Ankle	____	____	_____
Lower Leg/Knee	____	____	_____
Thigh/Hip/Groin	____	____	_____
Back/Ribs	____	____	_____
Neck/Shoulder	____	____	_____
Arm/Elbow/Wrist	____	____	_____
Hand/Fingers	____	____	_____
Other	____	____	_____

Please list any other pertinent medical history: _____

_____

Current Vitals: Height: _____ Weight: _____ Pulse: _____ BP: _____

The above named individual has had a physical examination and is cleared for activity at the College Connection Showcase.

*__Health Care Provider Signature__: _____ Date: _____

** If a signed school form is **NOT** attached, this document **must be signed/stamped to be valid**

HCP Name (Printed): _____

HCP Address: _____ **HCP** Phone: _____

**** Participant:** The responses to the questions on this form are correct to the best of my knowledge.

Participant's Signature: _____ Date: _____

Must be signed to be valid

***** Parent/Guardian:**

I understand and accept that risk of injury is possible while playing or practicing the sport of field hockey. I authorize the directors to act for me according to their best judgment in any emergency requiring medical attention.

Parent and/or Guardian's Signature: _____ Date: _____

Must be signed to be valid

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Please DO NOT mail, fax or email this Form