



College Connection Showcases: 2026 HEALTH FORM

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

** If you wish to supply a valid 2025 – 2026 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)

Table with 3 columns: DISEASE, VACCINATION, IMMUNIZATION. Rows include Measles, Hepatitis B, 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?

Table with 4 columns: General, Yes, No, Briefly Explain. Rows include 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