Dear Student-Athlete,

Welcome to the Lighthouse Christian College athletic family. The enclosed forms are required before you can participate in any team activity. The information provided will be kept confidential, but is required by Lighthouse Christian College and follows USCAA recommendations.

Lighthouse Christian College requires that athletes maintain a primary medical insurance policy for the entire school year which includes coverage for intercollegiate athletics. This policy may be obtained through a parent or purchased individually. If you must purchase your own policy, make sure you purchase it early enough you can receive your insurance cards prior to arriving at LCC. The effective date for your insurance should be at least one day before the start of fall camp or one day before the start of classes if your team does not report before classes begin. Before coming to college, check with your insurance company to confirm they provide coverage in Florida for both emergency and non-emergency care. If you have Medicaid or a HMO insurance policy and need to designate a new primary physician, the closest medical clinic is in Milton, FL

- If you have Medicaid or an HMO as your primary health insurance, please be aware coverage may vary depending on which state you receive care in. Some insurance companies do not provide coverage for non-emergency care if it is received outside of your home state or insurance network. Please contact your insurance carrier to verify coverage in the State of Florida. If your insurance does not provide full coverage in Florida, it is recommended you obtain coverage which does cover you in Florida. Insurance coverage must be maintained for the full school year to be cleared to participate. Any change or loss of coverage must be immediately reported to the athletic training or coaching staff. **Thank you for completing the paperwork and returning it to the Athletic Office.**

Department. This information is only for athletic training purposes and will not be used by any other department. Feel free to contact the Athletic Department with any information or questions you may have regarding these forms or insurance.

Sincerely,

Ricky Broxson

Vice President Of Athletics

ricky.broxson@lighthousepca.com

850-704-7048

Robert Schneider

Director of Football/ Chairman of the Board

r.schneider

850-499-1806

REQUIRED INFORMATION

Before you can participate in LCC varsity practices you MUST have:

If you are under the age of 18, a parent/guardian must co-sign all paperwork

1. Complete pages 3-11 of the physical packet. Make sure all pages are completed fully, legibly and signed where necessary.

2. Current physical – Have your medical provider complete page 12. This must be completed before reporting for first practice or camp for football, basketball, or baseball. ***We do not accept physicals performed by chiropractors.**

3. Submit a copy of the front and back of your insurance card with your physical packet.

4. All paperwork should be completed and returned to the athletic office department by July 15th.

    a. Paperwork may be scanned and sent as a pdf attachment to ricky.broxson@lighthousepca.com or football to r.schneider@lighthousepca.com

Do Not Return This Page

LIGHTHOUSE CHRISTIAN COLLEGE NEW ATHLETE MEDICAL HISTORY

Name: _____ Age: _____ Date Of Birth: _____

Sport: _____men's or women's Cell Phone _____

INSTRUCTIONS: Lighthouse Christian College requires all athletes to have a yearly physical examination and primary medical insurance. An athlete cannot participate until all paperwork is completed and on file in the athletic training department. Further, the College does not assume any responsibility for medical bills incurred. Athletes must maintain primary, major medical insurance, which provides coverage for injuries sustained in intercollegiate athletics.

EMERGENCY NOTIFICATION INFORMATION

Person to notify in case of an emergency:

Name: _____ Relationship: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____)_____ Cell Phone: (_____)_____

INSURANCE INFORMATION

Policy Holder's Name: _____ _____
(Last) (First) (MI) Date of Birth

Insurance Company: _____ ID # _____

INSURANCE MUST COVER INTERCOLLEGIATE ATHLETICS Is your primary insurance an HMO PPO

If you have Medicaid or an HMO as your primary health insurance, please be aware coverage may vary depending on which state you receive care in. Some insurance companies do not provide coverage for non-emergency care if it is received outside of your home state or insurance network. Please contact your insurance carrier to verify coverage in the State of Florida. If your insurance does not provide full coverage in Florida, it is recommended you obtain coverage which does cover you in Florida. Insurance coverage must be maintained for the full school year to be cleared to participate. Any change or loss of coverage must be immediately reported to the athletic training staff.

I hereby acknowledge I have read and understand the requirements for sports participation and an insurance plan. I also acknowledge the above information is accurate and correct to the best of my knowledge. I hereby authorize Lighthouse Christian College to inspect and secure copies of medical records, laboratory reports, diagnoses, x-rays, and other data covering any confinements or disability related to any injuries from participation and/or any previous confinements and/or disabilities. A photocopy or facsimile of this authorization shall be deemed as valid as the original until revoked by me in writing.

I grant the athletic trainers, team physicians, coaches, and consultants of Lighthouse Christian College to render me any emergency care, or other medical or surgical care which might be deemed necessary to insure proper care of any injury/illness, and to maintain my health and wellbeing. In the absence of the team or authorized physician, I grant permission to a qualified physician to furnish emergency care using the guidelines above. Also, when necessary for executing such care, permission for hospitalization at an accredited hospital is granted.

_____ _____ _____
Athlete Printed Name Athlete Signature Date

_____ _____
Parent Signature (Required if athlete is less than 18) Date

FAMILY MEDICAL HISTORY: Has any immediate family member ever had?

Cancer	**YES**	**NO**	Stroke	**YES**	**NO**	Sickle Cell Trait/Disease	**YES**	**NO**
Diabetes	**YES**	**NO**	Epilepsy/Seizures	**YES**	**NO**	Die suddenly before age 50 years	**YES**	**NO**
Heart Trouble	**YES**	**NO**	Mental Illness/Depression	**YES**	**NO**			
High Blood Pressure	**YES**	**NO**	Suicide	**YES**	**NO**			

Other, please explain:

MEDICAL ILLNESS HISTORY

Have you ever had or do you now have any of the conditions below?

CHECK EACH ITEM	YES	NO	AGE	CHECK EACH ITEM	YES	NO	AGE	CHECK EACH ITEM	YES	NO	AGE
Palpitation or Pounding Heart				Ear, Nose, or Throat Trouble				Hypoglycemia (low blood sugar)			
High Blood Pressure				Kidney Trouble				Diabetes			
Heart Problems/Murmur				Intestinal Trouble				Psychiatric Problems			
Chronic Cough				Liver Trouble				Depression			
Pain/Pressure in Chest				Hernia				Insomnia			
Shortness of Breath				Gall Bladder Trouble				Neuritis			
Asthma				Appendicitis				Seizures			
Bronchitis				Bloody Urine				Dizziness			
Glaucoma				Tumor/Growth/ Cyst				Amnesia			
Retinal Detachment				Cancer				Sickle Cell Anemia			
Heat Exhaustion				Mononucleosis				Fainting			
Heat Stroke				Anemia				Lyme Disease			

GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items?

Aspirin	**YES**	**NO**	Naproxen	**YES**	**NO**	Sulfa Drugs	**YES**	**NO**	Peanuts/tree nuts	**YES**	**NO**
Penicillin	**YES**	**NO**	Ibuprofen	**YES**	**NO**	Bee/Wasp stings	**YES**	**NO**	Shellfish	**YES**	**NO**

1. If you answered yes to any of the allergies above, do you carry an Epi-Pen auto injector?	**YES**	**NO**
2. Do you carry an inhaler for breathing problems?	**YES**	**NO**
3. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:	**YES**	**NO**

GENERAL MEDICAL INFORMATION: (CIRCLE THE CORRECT ANSWER)

1. Have you ever been tested for sickle cell trait? • If yes, were the results Positive or Negative? (circle one)					**YES**	**NO**
2. Have you ever had a Concussion? If yes, please list the number of times and the date of each:					**YES**	**NO**
3. Do you have a vision defect in either one or both eyes and if yes, please specify:					**YES**	**NO**
4. Do you wear glasses?	**YES**	**NO**	Do you wear contact lenses?	**YES**	**NO**	
5. Do you wear any dental appliances?	**YES**	**NO**	If so, do you wear them during practice?	**YES**	**NO**	
6. If yes, circle the appropriate appliance: Corrective Braces. Permanent Bridge, Permanent Crown or Jacket, Removable Partial or Full Plate						
7. Have you ever lost the full use of any organs, either temporarily or permanently? If yes, please list the organ(s) and details regarding the loss including the dates and treating physicians for each:					**YES**	**NO**
8. Have you ever had surgery to repair or remove any organ? If yes, please list the organ(s) and details regarding the repair and/or removal:					**YES**	**NO**

Orthopedic Injuries:

Have you ever had a fracture or dislocation? **YES** **NO**
If yes, please indicate the body part in the chart below:

BODY PART	DATES	BODY PART	DATES
SKULL		COLLAR BONE	
NOSE		UPPER ARM	
FACE		FOREARM	
JAW		WRIST	
NECK		HAND	
SPINE		THIGH	
PELVIS		LOWER LEG	
RIBS		FOOT	
SHOULDER		KNEE CAP	
ANKLE		ELBOW	
FINGERS		TOES	

If the fracture/dislocation required surgery, please explain.

Please list any ligament, tendon or meniscus injuries you have had.

All statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand this information is used to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses I may incur.

Athlete Printed Name _____ Athlete Signature _____ Date _____

Parent Signature (Required if athlete is less than 18) _____ Date _____

Symptom Score Sheet

Have you ever had a concussion? YES NO

If yes, date of last concussion:_____

Please circle the number below which indicates the degree to which you are CURRENTLY experiencing the following symptoms: (Complete this section even if you have never had a concussion)

	Symptom Severity Rating						
Symptoms	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Lightheadedness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous/Anxious	0	1	2	3	4	5	6
Feeling more emotional	0	1	2	3	4	5	6
Numbness or tingling	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Visual Problems	0	1	2	3	4	5	6
Other	0	1	2	3	4	5	6

I understand I have a responsibility, and am required, to report any suspected concussions to a member of the athletic training department. I understand I cannot continue to practice or play if there is the possibility I have sustained a concussion, until I have been cleared by a member of the athletic training staff.

_____ _____ _____

Athlete Printed Name Athlete Signature Date

_____ _____

Parent Signature (Required if athlete is less than 18) Date

Lighthouse Christian College - Department of Athletics
Assumption of Risk and Medical Waiver Form

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving **MANY RISKS OF INJURY**, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, concussions, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my body, general health and well-being.

Additionally, I acknowledge that COVID-19 is a public health risk, and the Lighthouse Christian College, LCC Athletics and all its trustees, officers, administrators, agents, employees and volunteers cannot guarantee safety or immunity from infection, and that I am electing to participate in intercollegiate athletics.

Because of the aforementioned dangers of participating in any athletic activity:

- I recognize the importance of following all instructions of the coaching staff, strength and conditioning staff, and/or Athletic Training staff. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics.

- I grant the athletic trainers, team physicians, therapists, technicians, and consultants of LCC to render me any emergency care, or other medical or surgical care that might be deemed necessary to insure proper care of any injury/illness, and to maintain my health and well-being. In the absence of the team or authorized physician, I grant permission to a qualified physician to furnish emergency care using the guidelines above. Also when necessary for executing such care, permission for hospitalization at a hospital is granted.

- I further understand that it is my responsibility to notify the LCC sports medicine staff in writing of any and all injuries/ illnesses or physical condition, athletic or otherwise, suspected injury/illnesses or physical condition, and any and all pre-existing conditions that may result in further injury/illness to myself, teammates, opponents, or athletic/sports medicine staff.

- I understand that I must refrain from practice or play during medical treatment until I am discharged from treatment or given a written permit by the attending physician to resume participation; that having passed a physical examination does not necessarily mean that I am physically qualified to engage in athletics; but only that the examiner did not find a medical reason to disqualify me; and fully realize that LCC cannot be held responsible for any medical condition(s) that I may have.

In consideration of LCC permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release Lighthouse Christian College and their officers, agents, and employees from any and all liability, any medical expenses, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at Lighthouse Christian College.

Athlete Printed Name	Athlete Signature	Date

Parent Signature (Required if athlete is less than 18)	Date

Lighthouse Christian College
Department of Athletics
Athlete Concussion Statement

_____ Initials — I understand it is my responsibility to report all injuries and illnesses to my athletic trainer; including concussions.

_____ Initials — I was provided a copy of the NCAA Concussion Fact Sheet and am aware of the following information:

_____ Initials — A concussion is a brain injury, which I am responsible for reporting to my athletic trainer.

_____ Initials — A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep and classroom performance.

_____ Initials — You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

_____ Initials — If I suspect a teammate has a concussion, I am responsible for reporting the injury to my athletic trainer.

_____ Initials — I will not return to play in a game or practice if I have received a blow to the head that results in concussion-related symptoms.

_____ Initials — Following a concussion, the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms have resolved.

_____ Initials — In rare cases, concussions can cause permanent brain damage and even death.

_____ Initials — Helmets, face shields, mouth guards and other protective equipment does not eliminate the risk of a concussion.

_____ Initials — Purposeful head and neck contact is not permitted and increases my risk for suffering a head injury.

_____ Initials — Participation in any sport carries the risk of suffering a concussion

_____ Athlete Printed Name

_____ Athlete Signature

_____ Date

_____ Parent Signature (Required if athlete is less than 18)

_____ Date

Lighthouse Christian College
Department of Athletics
Medication List

Please list all prescription medications you are currently taking. Some medications may cause you to test positive for the USCAA drug test and you must have prior approval by the USCAA in order to compete while taking these medications. Failure to list medications could cause you to test positive, resulting in forfeiture of competitions. If you do not take any prescription medications write **None**, then sign and date the form.

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____

9_____

10_____

11_____

12_____

By signing below, I acknowledge I have provided an accurate list of all prescription medications I am currently taking. I also understand I must provide an updated list if I am prescribed any new medications.

_____ _____ _____
Athlete Printed Name Athlete Signature Date

_____ _____
Parent Signature (Required if athlete is less than 18) Date

Lighthouse Christian College
Consent for Treatment

I authorize Lighthouse Christian College to provide medical and/or mental care to:

Name:_____ Date of Birth:_____

In case of mental health concern, illness, or injury, permission is hereby granted to treat the above named student as deemed necessary by the staff of Lighthouse Christian College. Services may include but are not limited to routine and emergency medical services (including examinations; laboratory, radiologic and other testing vaccinations; minor surgical procedures; prescription and other treatments), and mental health services. I understand that, in the case of a minor child, should said minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated. I further understand that, according to Florida state law, that once an individual reaches the age of 18, parental consent for treatment is no longer required. Parent or guardian consent is not legally required for minors who seek medical diagnosis and treatment for sexually transmitted diseases.
To the best of my knowledge, the above information is accurate. I understand the information I provided will be used to assist medical personnel in case of emergency.

_____	_____	_____
Athlete Printed Name	Athlete Signature	Date

_____	_____
Parent Signature (Required if athlete is less than 19)	Date

Immunization Records

All entering students must show a valid immunization record (2 shots) for measles, mumps, and rubella (MMR).

Lighthouse Christian College
Department of Athletics
Physical Exam

*We do not accept physicals performed by chiropractors

NAME: _____ AGE: _____ SPORT: _____ DATE: _____

WEIGHT: _____ HEIGHT: _____ Vision: R: _____/_____ L: _____/_____

BLOOD PRESSURE: _____ **PULSE: _____**

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
HEAD			RESPIRATORY		
NECK			MOUTH, TEETH		
EYES			HEART		
EAR, NOSE, THROAT			CHEST, LUNGS		
NEUROMUSCULAR			GENITALIA, HERNIA		
SKIN			ABDOMEN		
MUSCULOSKELETAL (ROM, Strength, etc)					
NECK			HIPS		
SPINE			THIGHS		
SHOULDERS			KNEES		
ARMS, HANDS			ANKLE, FEET		

Physicians Comments:

OVERALL PHYSICAL EXAMINATION RESULTS:

PASSED WITHOUT LIMITATIONS	
PASSED PENDING THE FOLLOWING	

Physician's Signature: _____ Date: _____
MD, DO, PA, or NP only

Physician's Printed Name or Stamp: _____