

**Lorain County Community College Sports**  
**Emergency Medical Information**  
(completed before individual can try-out or participate)

Student's Name (print) \_\_\_\_\_ LCCC ID # \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Emergency Contact (name & phone #'s)

1. \_\_\_\_\_  
(Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_

\_\_\_\_\_ (Day Telephone) \_\_\_\_\_ (Evening Phone)

2. \_\_\_\_\_  
(Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_

\_\_\_\_\_ (Day Telephone) \_\_\_\_\_ (Evening Phone)

Presently under the following medication: \_\_\_\_\_

Presently allergic to the following: \_\_\_\_\_

Presently wear contact lenses? \_\_\_\_\_ Presently wear glasses? \_\_\_\_\_

Please list any temporary or chronic illnesses or diseases from which you suffer: \_\_\_\_\_

Have you had any major injury, illness, or surgery relating to cerebral concussion, joint injury (knee, ankle, etc.), fracture, or organ loss previous to participation in LCCC Sport activities? \_\_\_\_\_ If so, please indicate why. \_\_\_\_\_

I am currently covered by medical insurance. \_\_\_\_\_ Yes \_\_\_\_\_ No

**\*All sports participants must provide their own insurance.\***

Please name Medical Insurance Agency \_\_\_\_\_

Name of the person the coverage is in \_\_\_\_\_

Do you know of, or believe there is any health reason why you should not participate in LCCC Sport Activities?

\_\_\_\_\_ . If so, please indicate why \_\_\_\_\_

Please complete reverse side and sign . . .

## LORAIN COUNTY COMMUNITY COLLEGE HPER

### Medical History/Waiver Form

Check (✓) the correct response.

Yes	Know	No	Do Not Know	I. <u>Coronary Primary Risk Factors?</u>
1. ___	___ mg/dl	___	___	1. Elevated Cholesterol ( <i>under age 30; 180mg/dl &amp; above</i> <i>over age 30; 200mg/dl &amp; above</i> )
2. ___	___	___	___	2. Hypertension ( <i>Resting Blood Pressure in excess of 140/90</i> )
3. ___	___	___	___	3. Cigarette Smoking
4. ___	___ mg/dl	___	___	4. Diabetes Mellitus ( <i>Fasting Blood Glucose Level above 140 mg/dl</i> )
5. ___	___	___	___	5. Abnormal (ECG) Electrocardiogram ( <i>Irregular Heart Beat</i> )
6. ___	___	___	___	6. Family History Of Heart Disease Prior to Age 50
7. ___	___	___	___	7. Low Cardiovascular Fitness Level/Sedentary Lifestyle
Yes	No	Do Not Know	II. <u>Coronary Secondary Risk Factors?</u>	
1. ___	___	___	1. Family History Of Heart Disease After Age 50	
2. ___	___	___	2. % Body Fat ( <i>Female: Over 30% - Male: Over 25%</i> )	
3. ___	___	___	3. Elevated Triglyceride Level ( <i>greater than 150mg/dl in blood</i> )	
4. ___	___	___	4. Chronic Stress ( <i>stressful lifestyle</i> )	
5. ___	___	___	5. Elevated Uric Acid Levels ( <i>greater than 8mg/dl</i> )	
6. ___	___	___	6. Excessive Alcohol Intake ___# <b>drinks per week</b> ( <i>&gt; 2 drinks per day: 5oz wine, or</i> <i>12oz beer, 1-1/2oz liquor</i> )	
7. ___	___	___	7. Type H Personality ( <i>hate or hostile personality type</i> )	
8. ___	___	___	8. Poor Lung Capacity ( <i>poor valves for vital capacity &amp; FEV Forced Expired Volume</i> )	
9. ___	___	___	9. Birth Control Pill Use	
10. ___	___	___	10. Post-menopausal Women ( <i>same risk as men of same age.</i> )	
III. <u>Par Q &amp; You*</u> <u>Physical Activity Readiness Questionnaire</u> *ACSM 5th Edition ( <i>rev 1994</i> )				
Yes	No	(The Par Q is used throughout North America.)		
1. ___	___	1. Has your doctor ever said you have a heart condition <u>and</u> you should only do physical activity recommended by a doctor?		
2. ___	___	2. Do you feel pain in your chest when you do physical activity?		
3. ___	___	3. In the past month, have you had chest pain when you were <b>NOT</b> doing physical activity?		
4. ___	___	4. Do you lose your balance because of dizziness or do you ever lose consciousness?		
5. ___	___	5. Any bone/joint problems that may be made worse by a change in physical activity?		
6. ___	___	6. Are you currently taking prescribed drugs ( <i>ex: water pills for blood pressure or heart condition?</i> )		
7. ___	___	7. Do you know of <u>any other reason</u> why you should <b>NOT</b> do physical activity?		
If "Yes" response, explain: _____.				

Yes	No	IV. Other Medical Concerns?
1. ___	___	1. Heart Surgery? If "Yes" response, describe: _____ Date: _____
2. ___	___	2. Other Surgery? If "Yes" response, describe: _____ Date: _____
3. ___	___	3. Bone, Orthopedic or Joint Problems? ___ shoulder, ___ low back, ___ knee, ___ hip, ___ muscular
4. ___	___	4. Other? ___ asthma, ___ anemia, ___ epilepsy, ___ seizures, ___ cancer, ___ currently pregnant
5. ___	___	5. Arthritis? ___ neck, ___ shoulder, ___ hips, ___ back, ___ hand(s), ___ knee(s)
6. ___	___	6. Medication? Description: _____

If "Yes" response to any of the above questions, explain: \_\_\_\_\_

If you responded "Yes" to any of the above questions, it is **RECOMMENDED** you consult your physician before continuing in this activity. This information is correct to the best of my knowledge.

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

*Emer/2005*