



## Seminole Community College

Department of Athletics 56 / Athletic Training  
100 Weldon Boulevard | Sanford, FL 32773-6199 | Phone: 407-708-2675 | FAX: 407-708-2142

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Dear Parent, Guardian and/or Student Athlete:

Another exciting academic year is quickly approaching and there is a lot to do in preparation for the academia and athletic challenges that lay ahead. Enclosed you will find a collection of documents to be carefully reviewed and completed as part of the process of readiness for Seminole Community College Athletics.

Please take the time necessary to carefully read through and complete all documentation enclosed in this packet. A checklist is provided in an effort to make this process more orderly.

All documentation with original signatures is due by the first Friday in August. Facsimiles will not be accepted. Pre-participation Physicals must be completed no sooner than June 1st and no later than the assigned reporting date in August. Feel free to contact the office of our team physician, Dr. Daniel Monette, for availability of physical screenings (contact information on page 2, charges may apply).

If there are any questions not already addressed in these pages, please feel free to use one of the following resources.

SCC Sports Medicine web pages: [www.scc-fl.edu/athletics/athletictraining](http://www.scc-fl.edu/athletics/athletictraining)

SCC Main Athletics Office: 407-708-2090 Monday – Thursday from 9:00 AM – 4:00 PM

SCC Head Athletic Trainer email: [conwayt@scc-fl.edu](mailto:conwayt@scc-fl.edu).

In Health,

Tara Conway  
Head Athletic Trainer



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### **For Your Records**

The Athletic Training Department enlists the valued expertise of the area's physicians and specialists in the extended care of your student-athlete. Below, please find a current listing of the physicians and specialists whom have graciously extended preferred appointment times to our athletes.

*Use of these physicians is not mandatory. You have the right to refuse treatment or refuse the use of our team physicians. You have the right to utilize your own physicians and specialists.*

#### **Family & Sports Medicine:**

Dr. Daniel R. Monette  
North Seminole Family Practice & Sports Medicine  
2209 French Avenue  
Sanford, FL 32771  
407-321-4230

#### **Spine Health**

Dr. Matthew Herba, D.C.  
Herba Family Chiropractic  
158 Tuskawilla Road, Suite 1308  
Winter Springs, FL 32708  
407-327-9000

#### **Orthopedic Specialist:**

Dr. Randy Schwartzberg  
Orlando Orthopaedic Center  
1000 West Broadway Street., Suite  
Oviedo, FL 32765  
407-977-3500  
<http://www.orlandoortho.com>

#### **Physical Medicine & Rehabilitation**

CORA Sports Medicine & Rehabilitation Clinics  
Longwood and Lake Mary Offices  
<http://www.corahealth.com/>  
<http://www.corahealth.com/clinics/florida.asp>

#### **Local Emergency Room(s):**

In the event of an emergency situation the Emergency Room services most likely to be utilized will be:

Orlando Regional South Seminole Hospital  
555 West State Road 434  
Longwood, Florida 32752  
407-767-1200

[http://www.orhs.org/comm\\_hosp/south\\_sem/index.cfm](http://www.orhs.org/comm_hosp/south_sem/index.cfm)

For a complete and up-to-date listing of our Sports Medicine Team, please visit our website at:  
<http://www.scc-fl.edu/athletics/athletictraining/>.



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## STUDENT-ATHLETE (S-A) CONTACT INFORMATION

*Please print legibly*

Student-Athlete(S-A) Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Gender: Male / Female      Date of Birth (DOB): \_\_\_\_/\_\_\_\_/\_\_\_\_      Sport: \_\_\_\_\_

### **S-A Permanent Contact Information (e.g. Home-town address)**

Permanent Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **S-A Local Contact Information (e.g. College Apartment address)**

Permanent Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Local Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ SCC Student ID: \_\_\_\_\_

### **First Guardian (Primary Insurance Policy Holder)**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

### **Second Guardian**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

### **Alternate Emergency**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### **Primary Care Physician Information**

Practice Name: \_\_\_\_\_ Physician's Name: \_\_\_\_\_  
Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## STUDENT-ATHLETE HEALTH HISTORY FORM

Student-Athlete(S-A) Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sport: \_\_\_\_\_

**Please indicate if you have ever had any of the following medical illnesses or issues**

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Had a serious injury/been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Had an unfavorable/ allergic reaction to a drug, antibiotic, and/or medicine?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Had a severe sprain/strain and/or fracture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Do you require daily medication?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Had a concussion and/or head injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Do you have any allergies?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Been unconscious for any other reason than anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Do you have only one of two paired, functioning organs (eyes, kidney, ovary, etc.)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Had a neck and/or back injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Been diagnosed with asthma?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Had a back injury or back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Been diagnosed with diabetes?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Had a history of burners, stingers, numbness, in neck shoulder, and/or hand?	<input type="checkbox"/> Yes <input type="checkbox"/> No	29. Experienced seizures or convulsions; and/or been diagnosed with epilepsy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Had a shoulder, elbow, and/or hand/wrist injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	30. Been diagnosed with kidney disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Had a hip and/or knee injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	31. Been diagnosed with a hernia?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Had a lower leg, ankle, and/or foot injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	32. Have you had chicken pox?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Had an operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	33. Have you ever been diagnosed with a tumor or ulcer?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Are you currently undergoing physical therapy or rehabilitation for an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	34. Do you require any special equipment to participate in athletics?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Do you have any medical problems about which we should be aware?	<input type="checkbox"/> Yes <input type="checkbox"/> No	35. Have you been told by a physician to restrict your activity or not to participate in a sport?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Do you wear contact lenses, glasses, and/or safety glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	36. Are you currently taking any short course medications for any illness?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Had frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	37. Do you have any ongoing or chronic illnesses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Had a heat related illness (heat cramps, heat exhaustion, and/or heat stroke)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	38. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorder?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. While exercising, has your heart ever "skipped" a beat, have you suffered from a "racing heart", severe chest pain, lightheadedness or fainted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	39. Do you take vitamins, amino acids, creatine, and/or any other dietary supplement?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Had a dental injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	40. Have you ever felt dizzy or passed out during or after exercise?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Do you wear a removable dental appliance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	41. Had trouble with coughing, wheezing, or breathing during or after exercise?
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Have you ever been diagnosed with pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	42. Have you ever been told you were anemic or had abnormal bleeding?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have you ever been diagnosed with measles, mumps, rheumatic fever, scarlet fever, tuberculosis, or sickle cell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	43. Have you ever been diagnosed with high blood pressure and/or high cholesterol?
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Been recently diagnosed with infectious mononucleosis ("mono"), hepatitis B or C, HIV/AIDS, and/or any other severe infectious disease/ viral infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	44. Do you know of, or do you believe there is any health reason why you should not participate in intercollegiate athletics at Seminole Community College?

**FEMALES ONLY!**

When did your last menstrual period begin? \_\_\_\_/\_\_\_\_/\_\_\_\_  
 How long does your menstrual period usually last? \_\_\_\_\_  
 How many menstrual periods have you had in the past months? \_\_\_\_\_  
 Do you take birth control pills? If so, which one(s)? \_\_\_\_\_  
 Do you take pain medication during your menstrual period? If so, which one(s)? \_\_\_\_\_

**If you answered "YES" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail (use additional sheet(s) if necessary).**

I, the undersigned, hereby acknowledge, affirm, and represent that all above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld/ If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I fully understand that **SEMINOLE COMMUNITY COLLEGE**, its agents, servants, trustees, and employees, disclaim liability, and will not be held liable for any injuries and/or illnesses not noted.

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If under 18, Parent/Guardian Signature

\_\_\_\_\_  
Date



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## STUDENT-ATHLETE PRE-PARTICIPATION HEALTH EXAMINATION FORM

(To be completed by the examining physician)

Student-Athlete(S-A) Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sport: \_\_\_\_\_

### **VITAL INFORMATION:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_

Vision: Corrected?  Yes  No Right: 20/\_\_\_\_ Left: 20/\_\_\_\_ Pupils Equal?  Yes  No

### **PHYSICAL EXAM:**

FINDINGS	NORMAL	ABNORMAL FINDINGS
APPEARANCE	<input type="checkbox"/>	
SKIN	<input type="checkbox"/>	
EYES	<input type="checkbox"/>	
EARS	<input type="checkbox"/>	
NOSE	<input type="checkbox"/>	
MOUTH/ THROAT	<input type="checkbox"/>	
LYMPH NODES	<input type="checkbox"/>	
HEART/ CARDIOVASCULAR	<input type="checkbox"/>	
PULMONARY/ LUNGS	<input type="checkbox"/>	
ABDOMEN/ GASTROINTESTINAL	<input type="checkbox"/>	
GENITALIA (HERNIA/TESTICLES)	<input type="checkbox"/>	
GENITOURINARY	<input type="checkbox"/>	
NEUROLOGICAL	<input type="checkbox"/>	
ORTHOPEDIC (SPINE)	<input type="checkbox"/>	
ORTHOPEDIC (UPPER EXTREMITY)	<input type="checkbox"/>	
ORTHOPEDIC (LOWER EXTREMITY)	<input type="checkbox"/>	

### **ASSESSMENT OF EXAMINING PHYSICIAN:**

Cleared without limitations  
 Cleared after completing evaluation/ rehabilitation for: \_\_\_\_\_

Not cleared due to: \_\_\_\_\_

Recommendations/ Referrals: \_\_\_\_\_

_____ Physician's Printed Name	_____ Street Address, City, State, Zip
_____ Physician's Signature	_____ Date



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## STUDENT-ATHLETE PRIVATE HEALTH INFORMATION RELEASE FORM

TO ALL UNIVERSITIES, COLLEGES, HIGH SCHOOLS, STUDENT HEALTH SERVICES, CERTIFIED ATHLETIC TRAINERS, PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, PHYSICIANS, PHYSICIANS ASSISTANTS, HOSPITALS, CLINICS, DISPENSARIES, SANITARIUMS, HEALTH & AUTO INSURANCE PROVIDERS, AND OTHER RELATED HEALTH CARE AGENCIES:

You are hereby authorized and requested to send to and/or share with Seminole Community College's: Certified Athletic Trainers; Physical Therapists; Occupational Therapists; Physicians; and/or clinics (henceforth referred to as "SCC Sports Medicine"), a complete copy of all medical records pertaining to my medical condition, including all physical examinations; physician's records; Certified Athletic Trainer's records; musculo-skeletal rehabilitation records, diagnosis, treatment, history, and prognosis of any and all injuries/illnesses; and to receive from you any and all other information pertaining to my past and present medical condition, diagnosis, treatment, history, and prognosis from your personal knowledge and/or records. This authorization shall cover all past, present, and future medical conditions which might arise during my athletic participation with/at Seminole Community College. This authorization may be executed by SCC Department of Athletics/ Athletic Training for a period of 30 months from the date of signature or for a period of 6 months following cessation of participation; whichever is longer. A photocopy, electronic or telecommunication reproduction of this authorization shall be considered as effective and valid as the original.

Student-Athlete's Birth Name: \_\_\_\_\_  
Please PRINT LEGIBLY: First, Middle, and Last Name

Student-Athlete's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Student- Athlete: \_\_\_\_\_  
Signature Date

Parent/Guardian: \_\_\_\_\_  
If under 18, parent/guardian signature needed Date



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## STUDENT-ATHLETE INSURANCE INFORMATION FORM

*PLEASE READ THE FOLLOWING INFORMATION CAREFULLY*

- ❖ I/we hereby agree to supply any and all information requested by my primary insurance provider and Seminole Community College Athletics Department, its support staff, its coaches, and athletic trainers (henceforth collectively referred to as SCC) & SCC's excess insurance company(s) in a timely manner.
- ❖ I/we hereby authorize SCC and their affiliated health care providers to release any information concerning any illness, injury, treatments, and benefits payable to my and SCC insurance carriers. I/we further hereby authorize my and SCC insurance carriers to release information regarding medical, dental, treatment, or benefits-payable-to, or any other information necessary, to SCC Athletics, their employees, and authorized agents for the purpose of validating my claim and for reporting purposes.
- ❖ I/we hereby authorize SCC and their affiliated health care providers to hospitalize and/or secure treatment for the student-athlete whose name appears on this form in the event that I am unable to give consent to such treatment in order to protect and preserve my health and well being.
- ❖ **I/we agree to immediately notify SCC upon any change in residential, guardian, emergency, and/or health insurance information and/or status of coverage. Failure to provide updated information may result in overpayments and/or denial of payment by/from SCC's excess insurance company(s) for healthcare services rendered. I/we further understand and accept that any/all such balance of overpayments and/or denials are my/our responsibility and will be under obligation of reimbursement and/or payment in full, upon request, all amounts outstanding to SCC, SCC's affiliated health care providers, and/or SCC's excess insurance company.** \_\_\_\_\_ (initial after reading statement)
- ❖ **I/we understand that any information discovered to be incomplete, false, invalid, and/or otherwise out-of-date may result in the student-athlete's immediate removal and suspension from participation in all athletic related activities including but not limited to team: functions, meetings, practices, conditions, strength training, and competitions; until such information has been updated and verified with/by SCC.** \_\_\_\_\_ (initial after reading statement)
- ❖ I/we hereby acknowledge that although sufficient primary and/or supplemental accidental injury insurance may have been secured, I/we understand that I/we are responsible for any/all costs of medical treatment that may arise from/during participation in SCC Intercollegiate Athletics Program not covered by primary, supplemental, or secondary insurance policies.
- ❖ **College regulations require all students be covered under a primary insurance policy during participation in intercollegiate athletics. A photocopy of the front and back of the insurance card is required and will be retained in the student's medical file in the athletic training room.** \_\_\_\_\_ (initial after reading statement)
- ❖ For those student-athletes (S-A) who are covered by state or federal Medicare or Medicaid programs, it is strongly suggested that a Primary Care Physician from your program be selected closest to the Sanford, FL (32773) area. It is the responsibility of the S-A and/or guardian to locate and register with a local primary care physician as listed in their explanation of benefits. If a primary care physician local to SCC is not obtainable through your assigned health care benefit provisions, **ALL** medical conditions are required to be referred back to the S-A's home area physician at the S-A's expense or to the local emergency room. Any financial obligations billed to the S-A and/or their legal guardian are the responsibility of the S-A and/or legal guardian.
- ❖ I/we hereby certify that I/we have read and understand the above statements, that any and all questions have been answered to my satisfaction, and that the answers provided on this form and in the SCC pre-participation packet are true, complete and correct to the best of my/our knowledge.
- ❖ This authorization is valid for a period of 30 months from the date of signature or for a period of 6 months following cessation of participation; whichever is longer. A photocopy, electronic, or telecommunication reproduction of this authorization shall be deemed as effective and valid as the original.

I/we currently have sufficient PRIMARY health insurance coverage.

Company Name: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

I/we currently do not have sufficient PRIMARY health insurance coverage and agree to obtain sufficient coverage prior to the assigned reporting date.

Student-Athlete Signature

Date

If under 18, parent/guardian signature

Date



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## Acknowledgement and Agreement to Participate

### AT.F1.1 Statement of Present Physical Condition

I have previously represented to Seminole Community College (SCC) that I am physically and mentally capable of safe participation in SCC's Intercollegiate Athletics Program and related activities. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any: symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing, my prior medical history; that my health history form was fully and accurately completed; that all my present complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to and discussed with a SCC team and/or consulting physician and/or his/her designee; and that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions or problems not so disclosed and discussed.

\_\_\_\_\_ (please initial after reading the above statement)

### AT.F1.2 Statement of Participation

I have been advised that playing, practicing, training, and/or other involvement in any sport involves activities such as, but not limited to strenuous physical exercise, running, twisting, stretching, jumping, strength training, and physical contact with other players. I have been advised to consult with a physician concerning my fitness to participate in such activities.

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 have been advised that participation in SCC Intercollegiate Athletics Program and related activities may include, but are not limited to: strenuous physical activity, running, twisting, stretching, strength training, and physical contact with other players. I understand that the dangers and risks of these activities and in any athletic activity include, but are not limited to: communicable illness of varying degree and severity, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health, well-being, or even death.

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 sports medicine department. Furthermore, I understand that the possibility of illness and/or injury including catastrophic injury does exist even though proper rules and techniques are followed to the fullest. I also understand that there are associated risks involved with traveling in connection with intercollegiate athletics.

In consideration of SCC 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 exonerate, save harmless, and release SCC, its agents, servants, trustees, and employees from any and all liability, personal injury, property damage, medical expenses, 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 here of shall serve as release and assumption of risk from my heirs, estate, executor, administrators, assignees, and all members of my family.

\_\_\_\_\_ (please initial after reading the above statement)

### AT.F1.3 Department Drug Testing Acknowledgement and Hold Harmless Agreement

I understand and agree that I am subject to drug testing by the Seminole Community College Athletics Department at any time and place decided by the personnel of the above mentioned athletic department.

I hereby agree to indemnify and hold harmless Seminole Community College, its officers, trustees, employees, and agents from and against all claims, liabilities, judgments, damages, cause of action of any kind whatsoever, and expenses and costs (including reasonable attorney's fees) arising out of or related to the implementation of this drug testing policy.

A copy of SCC's athletics department's drug testing policy and procedure can be found on our website at

<http://www.scc-fl.edu/athletics/athletictraining/> or by request in writing to:

Athletics Office Supervisor, Seminole Community College, 100 Weldon Blvd, Sanford, FL 32773-6199.

\_\_\_\_\_ (please initial after reading the above statement)



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## Agreement of Participation

This document is to serve as an informed agreement and acknowledgement of the requirements and risks associated with participation of intercollegiate sports between Seminole Community College (herein referred to as "SCC"), the undersigned student-athlete, and the primary insurance policy holder (if different from the student-athlete).

I/we hereby attest to have read and understand the specified requirements, statements, and acknowledgements set forth in SCC Athletics' document, AT.F1.1,2,3, "Acknowledgement and Agreement to Participate". I/we further agree to abide by all regulations and/or statements can result in unfavorable outcomes such as, but not limited to: bodily injury, suspension from athletic participation, and/or financial obligations associated with received medical care and/or dismissal from SCC Athletics.

\_\_\_\_\_

Student-Athlete Signature

\_\_\_\_\_

Date

\_\_\_\_\_

If under 18, parent/guardian Signature

\_\_\_\_\_

Date

## **Please attach a copy of the front and back of your insurance card**

Return entire packet to:

Seminole Community College  
Athletic Training Department  
100 Weldon Boulevard  
Sanford, FL 32773

If you have questions, please contact Tara Conway -  
Phone: 407.708.2675 or email: [conwayt@scc.fl.edu](mailto:conwayt@scc.fl.edu)