

Wenatchee Valley College **Returning Athletes**

 email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month/Day/Year

Local Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number & Street) (City) (Zip)

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number & Street) (City) (Zip)



Parent(s) Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number & Street) (City) (Zip)



Are you covered by group or individual health and/or accident insurance? Yes ❑ No ❑

If yes, please provide the following information:

Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID ~~Soc.Sec.~~ #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_



Please check ALL appropriate boxes for the sports in which you will be participating at this college:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❑ Baseball | ❑ M Basketball | ❑ M Golf | ❑ M Track | ❑ M Rodeo |
| ❑ Softball | ❑ W Basketball | ❑ W Golf | ❑ W Track | ❑ W Rodeo |
| ❑ Volleyball | ❑ M Cross Country | ❑ M Soccer | ❑ M Tennis | ❑ M Wrestling |
|  | ❑ W Cross Country | ❑ W Soccer | ❑ W Tennis | ❑ W Wrestling |

Medical Considerations (e.g., medical conditions, allergies, or current medications)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Returning Athletes Form**

**In the past year, have you had any of the following:**

**IMMUNIZATION RECORD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Measles\* | ❑ Yes | ❑ No | Date of last shot | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mumps\* | ❑ Yes | ❑ No | Date of last shot | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Rubella\* | ❑ Yes | ❑ No | Date of last shot | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Polio | ❑ Yes | ❑ No | Date of last dose | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Tetanus (Td) | ❑ Yes | ❑ No | Date of last shot | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*Note: These are commonly noted on immunization records as "MMR" and often given as one shot.

A second dose of measles vaccine is recommended for college entrance.

**FAMILY MEDICAL HISTORY**

*Please check YES or NO in appropriate box.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | ❑ Yes | ❑ No | Osteoporosis |  | 5. | ❑ Yes | ❑ No | Hemophilia |
| 2. | ❑ Yes | ❑ No | High blood pressure |  | 6. | ❑ Yes | ❑ No | Diabetes |
| 3. | ❑ Yes | ❑ No | Neuromuscular disease |  | 7. | ❑ Yes | ❑ No | Anemia |
| 4. | ❑ Yes | ❑ No | Sudden death from heart disease or stroke |  | 8. | ❑ Yes | ❑ No | Cancer |

*If living, please check box to signify family member's general health. If deceased, please state age and cause of death, if known.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  | Age at Death Cause of Death |
| Father | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother #1 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brother #2 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sister #1 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sister #2 | ❑ Excellent | ❑ Good | ❑ Fair | ❑ Poor | ❑ Deceased | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**MEDICAL CONDITIONS & ILLNESSES**

*Have you ever had or do you now have any of the following medical conditions, illnesses or diseases?*

*Please check YES or NO for EACH item.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  |  |  | **YES** | **NO** |  |  |  | **YES** | **NO** |  |
| 9. | ❑ | ❑ | Polio |  | 26. | ❑ | ❑ | Recurrent sinusitis |  | 43. | ❑ | ❑ | Hernia or rupture |
| 10. | ❑ | ❑ | Diphtheria |  | 27. | ❑ | ❑ | Hearing loss/ear disease |  | 44. | ❑ | ❑ | Ulcers |
| 11. | ❑ | ❑ | Rheumatic fever |  | 28. | ❑ | ❑ | Rheumatic heart disease |  | 45. | ❑ | ❑ | Testicular masses |
| 12. | ❑ | ❑ | Hepatitis |  | 29. | ❑ | ❑ | Heart murmur/problems |  | 46. | ❑ | ❑ | Hemorrhoids |
| 13. | ❑ | ❑ | Tuberculosis |  | 30. | ❑ | ❑ | Pericarditis |  | 47. | ❑ | ❑ | Bleeding disease |
| 14. | ❑ | ❑ | Collapsed lung |  | 31. | ❑ | ❑ | High blood pressure |  | 48. | ❑ | ❑ | Anemia |
| 15. | ❑ | ❑ | Pneumonia |  | 32. | ❑ | ❑ | Elevated cholesterol |  | 49. | ❑ | ❑ | Phlebitis |
| 16. | ❑ | ❑ | Pleurisy |  | 33. | ❑ | ❑ | Arthritis/joint problems |  | 50. | ❑ | ❑ | Asthma/hay fever |
| 17. | ❑ | ❑ | Diabetes |  | 34. | ❑ | ❑ | Bone infection |  | 51. | ❑ | ❑ | Skin disease/rash |
| 18. | ❑ | ❑ | Allergies |  | 35. | ❑ | ❑ | Chondromalacia |  | 52. | ❑ | ❑ | Measles |
| 19. | ❑ | ❑ | Tumors/Cancer |  | 36. | ❑ | ❑ | Seizures/Epilepsy |  | 53. | ❑ | ❑ | Mumps |
| 20. | ❑ | ❑ | Muscular disease |  | 37. | ❑ | ❑ | Migraine headaches |  | 54. | ❑ | ❑ | Mononucleosis |
| 21. | ❑ | ❑ | Eye disease |  | 38. | ❑ | ❑ | Neurological disorder |  | 55. | ❑ | ❑ | Malaria |
| 22. | ❑ | ❑ | Color blindness |  | 39. | ❑ | ❑ | Goiter/thyroid disease |  | 56. | ❑ | ❑ | Car or air sickness |
| 23. | ❑ | ❑ | Near sightedness |  | 40. | ❑ | ❑ | Enlarged organs (spleen) |  | 57. | ❑ | ❑ | Nervous breakdown |
| 24. | ❑ | ❑ | Far sightedness |  | 41. | ❑ | ❑ | Kidney or bladder disease |  | 58. | ❑ | ❑ | Mental disorder |
| 25. | ❑ | ❑ | Nasal polyps |  | 42. | ❑ | ❑ | Gastrointestinal bleeding |  | 59. | ❑ | ❑ | Eating disorder |

**INJURIES & SYMPTOMS**

*Do currently have or have you ever had any of the following symptoms, problems or injuries?*

*Please check YES or NO for EACH item.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  |  |  | **YES** | **NO** |  |  |  | **YES** | **NO** |  |
| 60. | ❑ | ❑ | Frequent headache |  | 71. | ❑ | ❑ | Neck pain or injury |  | 82. | ❑ | ❑ | Muscle weakness |
| 61. | ❑ | ❑ | Head injury |  | 72. | ❑ | ❑ | Back pain or injury |  | 83. | ❑ | ❑ | Muscle cramps |
| 62. | ❑ | ❑ | Visual changes |  | 73. | ❑ | ❑ | Knee pain or injury |  | 84. | ❑ | ❑ | Muscle wasting |
| 63. | ❑ | ❑ | Eye pain or injury |  | 74. | ❑ | ❑ | Ankle pain or injury |  | 85. | ❑ | ❑ | Frequent nausea |
| 64. | ❑ | ❑ | Ringing in ears |  | 75. | ❑ | ❑ | Shoulder dislocation/sep. |  | 86. | ❑ | ❑ | Frequent vomiting |
| 65. | ❑ | ❑ | Sore throats |  | 76. | ❑ | ❑ | Other joint sprain/disloc. |  | 87. | ❑ | ❑ | Frequent diarrhea |
| 66. | ❑ | ❑ | Nasal fracture |  | 77. | ❑ | ❑ | Joint pain, at rest |  | 88. | ❑ | ❑ | Abdominal problems |
| 67. | ❑ | ❑ | Sinus congestion |  | 78. | ❑ | ❑ | Joint pain, with exercise |  | 89. | ❑ | ❑ | Internal injuries |
| 68. | ❑ | ❑ | Breathing difficulty |  | 79. | ❑ | ❑ | Joint weakness |  | 90. | ❑ | ❑ | Rectal bleeding |
| 69. | ❑ | ❑ | Recurrent coughing |  | 80. | ❑ | ❑ | Pinched nerve |  | 91. | ❑ | ❑ | Unusual fatigue |
| 70. | ❑ | ❑ | Chest pain |  | 81. | ❑ | ❑ | Heat exhaustion/stoke |  | 92. | ❑ | ❑ | Trouble sleeping |

**GENERAL QUESTIONS**

*Please answer ALL of the following questions by checking either YES or NO for EACH item.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** |  |
| 93. | ❑ | ❑ | Do you now have or have you ever had any chronic or recurrent illnesses? |
| 94. | ❑ | ❑ | Have you ever had any illnesses lasting more than one week? |
| 95. | ❑ | ❑ | If no to #93 or #94, do you now have or have you ever had any illnesses requiring treatment and care of a doctor? |
| 96. | ❑ | ❑ | Do you wear eyeglasses or contact lenses? |
| 97. | ❑ | ❑ | Do you currently wear eyeglasses or contact lenses while participating in sports? |
| 98. | ❑ | ❑ | Do you use any dental appliances such as braces, bridges or plates? |
| 99. | ❑ | ❑ | Any body parts or organs missing (appendix, eye, kidney, testicles)? |
| 100. | ❑ | ❑ | Are you now or have you ever been under the treatment of a medical doctor for any injuries? |
| 101. | ❑ | ❑ | Have you ever fainted, passed out, been dizzy, knocked out, unconscious or had a concussion? |
| 102. | ❑ | ❑ | Have you ever had a cast, splint, cane or crutches? |
| 103. | ❑ | ❑ | Have you ever had an X-ray of any bone or joint? |
| 104. | ❑ | ❑ | Do you have to stop while running twice around a quarter-mile track? |
| 105. | ❑ | ❑ | Do you have any trouble breathing, while at rest, after running one mile? |
| 106. | ❑ | ❑ | Do you get any chest pain with exercise? |
| 107. | ❑ | ❑ | Have you ever had any injuries or illnesses that caused you to miss a game or practice? |
| 108. | ❑ | ❑ | Are there any reasons why you should not participate in sports? |
| 109. | ❑ | ❑ | Have any of your close relatives, under the age of 50, died of heart problems or unexplained causes? |
| 110. | ❑ | ❑ | Are you or any member of your family allergic to ANY medications (aspirin, penicillin, etc.)? |
| 111. | ❑ | ❑ | Are you now taking or have you taken any medications, medicines, drugs or vitamins on a regular basis? |
| 112. | ❑ | ❑ | Do you have any medical conditions that require special attention or treatment that the coach or athletic trainer should be aware of in the event of any injury or illness? |

*If you have answered "****Yes****" to any numbered item (1-112), please explain the situation or circumstances, including names of treating physicians and dates in the space provided. Identify each response by the number of the item in the left margin.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Item No.** | **Physician, City, State** | **Approx. Date** | **Explanation, including any surgeries you have had** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

***Please list all previous fractures, concussions or other head injuries:***

|  |  |  |  |
| --- | --- | --- | --- |
| **Item No.** | **Physician, City, State** | **Approx. Date** | **Injury** |
|  |  |  |  |
|  |  |  |  |

***Please list all hospitalizations:***

|  |  |  |  |
| --- | --- | --- | --- |
| **Item No.** | **Physician, City, State** | **Approx. Date** | **Reason for hospitalization, length of stay** |
|  |  |  |  |
|  |  |  |  |

***Describe your current pattern of physical exercise***

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Frequency | Duration | Intensity |
|  |  |  |  |
|  |  |  |  |

Describe the sickest you have ever been \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any weight changes over the last six months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List *all* medications -- prescription and/or over the counter -- drugs or vitamins that you currently take (including aspirin, birth control

pills, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any allergies -- from bites, drugs, foods, pollen, etc. -- you may have, including causes and reactions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you have your first menstrual period? \_\_\_\_\_\_ How many have you had during the last 12 months? \_\_\_\_\_\_\_

Date of last period \_\_\_\_\_\_\_\_ Describe any menstrual irregularity or discomfort\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGREEMENT OF UNDERSTANDING**

I, the undersigned, certify that the above medical history is correct and true to the best of my knowledge, and that this student has no physical defects except as stated. This medical information is given with my permission and the medical examination is taken voluntarily. I further understand that any intentional omission of answers either verbally or in writing may result in disqualification from the community college sports program.

I authorize the release of this medical information, including the medical examination and the results of any medical tests, to the college for their use, evaluation and record keeping for this student-athlete's participation in the sports program of the college. I further authorize the release of this medical information, the medical examination and the results of any medical tests when deemed necessary by the college athletic coach, athletic trainer or other authorized college official; and I grant permission to any hospital, physician, surgeon, or other duly authorized medical personnel to release any other medical records, charts or diagnoses when deemed necessary for the treatment and care of this student-athlete in the event of injury or illness.

I further authorize and request the college's designated medical personnel to administer basic life support, advanced life support, and/or to obtain emergency medical care in the event of injury or illness at any specific emergency care facility so designated by the college physician or representative while participating in the sports program.

By my signature I verify that I have read, understand and agree to the above-stated conditions.

Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (If student is under 18 years of age)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Mid. Initial)

**NWAC (2018)**