

**PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY**

This **MEDICAL HISTORY FORM** must be completed **annually** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

*In case of emergency, contact:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Explain "Yes" answers in the box below\*\*. Circle questions you don't know the answers to.

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
1. Have you had a medical illness or injury since your last check up or physical?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever gotten unexpectedly short of breath with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had prior testing for the heart ordered by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Has a physician ever denied or restricted your participation in activities for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
4. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____			18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last concussion? _____			<i>Females Only</i>		
How severe was each one? (Explain below)			19. When was your first menstrual period? _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent menstrual period? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	How much time do you usually have from the start of one period to the start of another? _____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	What was the longest time between periods in the last year? _____		
5. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Males Only</i>		
6. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	20. Do you have two testicles? _____		
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	21. Do you have any testicular swelling or masses? _____		
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.		
9. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):		
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>			

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the Texas College nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the Texas College.**

Student Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in Texas College practices, games or matches. **THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

**For School Use Only:**

This Medical History Form was reviewed by: Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

**PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION**

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)  
brachial blood pressure while sitting

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected:  Y  N Pupils:  Equal  Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. \* **Local district policy may require an annual physical exam.**

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

**MUSCULOSKELETAL**

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*station-based examination only

**CLEARANCE**

Cleared  
 Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/games/matches.

2024-2025

Texas College Department of Athletics



**Medical Waiver Form**

I have had a complete physical examination. I have completed a Medical History Questionnaire to the best of my knowledge and have discussed with the TC athletic trainer and/or medical consultants my prior medical history as well as all existing complaints, injuries, ailments and symptoms. I also affirm that I do not suffer from any disability, injury, condition, complaint, or problem that I have NOT DISCLOSED on and such forms and/or have not discussed with the athletic trainer and/or medical consultants. Also, I recognize the importance of fully and accurately disclosing my physical condition, past and present, with the Texas College Athletic Trainer and/or medical consultants.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

2024-2025

**Texas College Athletic Training  
Student Athlete Emergency and Insurance Information**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender \_\_\_\_\_

Students Social Security Number: \_\_\_-\_\_\_-\_\_\_\_\_ Student number \_\_\_\_\_

Student Email Address: \_\_\_\_\_ Student's phone # \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State and zip \_\_\_\_\_

Name of Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

**The following information is very important to have on file in case of an emergency situation. Please fill in the information to the best of your abilities. Please list any insurance coverage, including Student, Medicare, Medicaid, accident policies, HMO's, etc.**

Primary Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**It is required that we have a copy of your health insurance ID card(s) on file. Be sure to include a copy of the front and back of the card along with your completed forms**

**Health Information:**

Known Allergies (food, insects, latex, etc.) \_\_\_\_\_

Known Medical Conditions (diabetes, asthma, epilepsy, etc): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Do you know if you have Sickle Cell Trait: No Yes If yes, have you ever had problems and what kind?

Any other health related issues:

**Please complete this form entirely! If the answer is no, please write no, none or n/a. Do NOT leave anything blank!**

2024-2025

**Form C1**

Name \_\_\_\_\_

Sport \_\_\_\_\_

**Texas College  
Catastrophic Injury Assumption of Risk, Release of Claims and Indemnity Agreement**

Student-Athlete: \_\_\_\_\_ Sport(s): \_\_\_\_\_

I, the above named student-athlete, am eighteen years of age or older. I acknowledge that participation in the above activity may expose me to hazards or risks that may result in my illness, personal injury or death and I understand and appreciate the nature of such hazards and risks.

In consideration of my participation in the described sport under the auspices of the Department of Intercollegiate Athletics at Texas College and of my use of the program's facilities and equipment, I hereby accept all risk to my health and of my injury or death that may result from such participation. I hereby release the above named Institution, its governing board, officers, employees and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligence or intentional act or omission while participating in the activity.

**I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR MY INJURY OR DEATH OR DAMAGE TO MY PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY MY NEGLIGENCE OR INTENTIONAL ACT OR OMISSION.**

\_\_\_\_\_  
Student-Athlete's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**This form is to be filled out if student athlete is 18 years or older.**

2024-2025

**Form C2**

Name \_\_\_\_\_  
Sport \_\_\_\_\_

**Texas College  
Catastrophic Injury Assumption of Risk, Release of Claims and Indemnity Agreement**

Student-Athlete: \_\_\_\_\_ Sport(s): \_\_\_\_\_

I am the Parent/Guardian of the above named student-athlete who is **under eighteen years of age** and am fully competent to sign this agreement.

In consideration of my son/daughter to participate in the described sport under the auspices of the Department of Intercollegiate Athletics at Texas College and to use the program’s facilities and equipment, I hereby accept all risk to the participant’s health and of his/her injury or death that may result from such participation. I hereby release the above named Institution, its governing board, officers, employees and representatives from any and all liability to the participant, participant’s personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to the participants property and for any and all illness or injury to participants person, including his/her death, that may result from or occur during athletics participation, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees and representatives from liability for the injury or death of any person(s) and damage to property that may result from participant’s negligence or intentional act or omission while participating in the activity.

**I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR PARTICIPANT’S INJURY OR DEATH OR DAMAGE TO PARTICIPANT’S PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY PARTICIPANT’S NEGLIGENCE OR INTENTIONAL ACT OR OMISSION.**

\_\_\_\_\_  
Parent/Guardian’s Signature                      Date                      Address (if different than student-athlete)

\_\_\_\_\_  
Witness Signature                                      Date

**This form is to be filled out by a parent if the student athlete is under 18.**

2024-2025

**Form D**

Name \_\_\_\_\_

Sport \_\_\_\_\_

**Texas College  
Consent to Treat**

I hereby grant permission to Texas College team physicians and/or their consulting physicians to provide (my son), (my daughter), (me) with any treatment or medical or surgical care that they deem reasonably necessary to the health and well being of the athlete. I also, hereby, authorize the athletic trainers at Texas College, who are under the direction and guidance of the Texas College team physicians, to provide (my son), (my daughter), (me) with any preventive, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to the health and well being of the athlete. Also, when necessary for providing such care, I grant permission for hospitalization at an accredited hospital. Furthermore, to the greatest extent allowed by law, I agree to release Texas College, Texas College's team physicians, its consulting physicians and athletic trainers from any and all claims arising from or related to the treatment or health care provided to the athlete.

\_\_\_\_\_  
Athlete's Signature

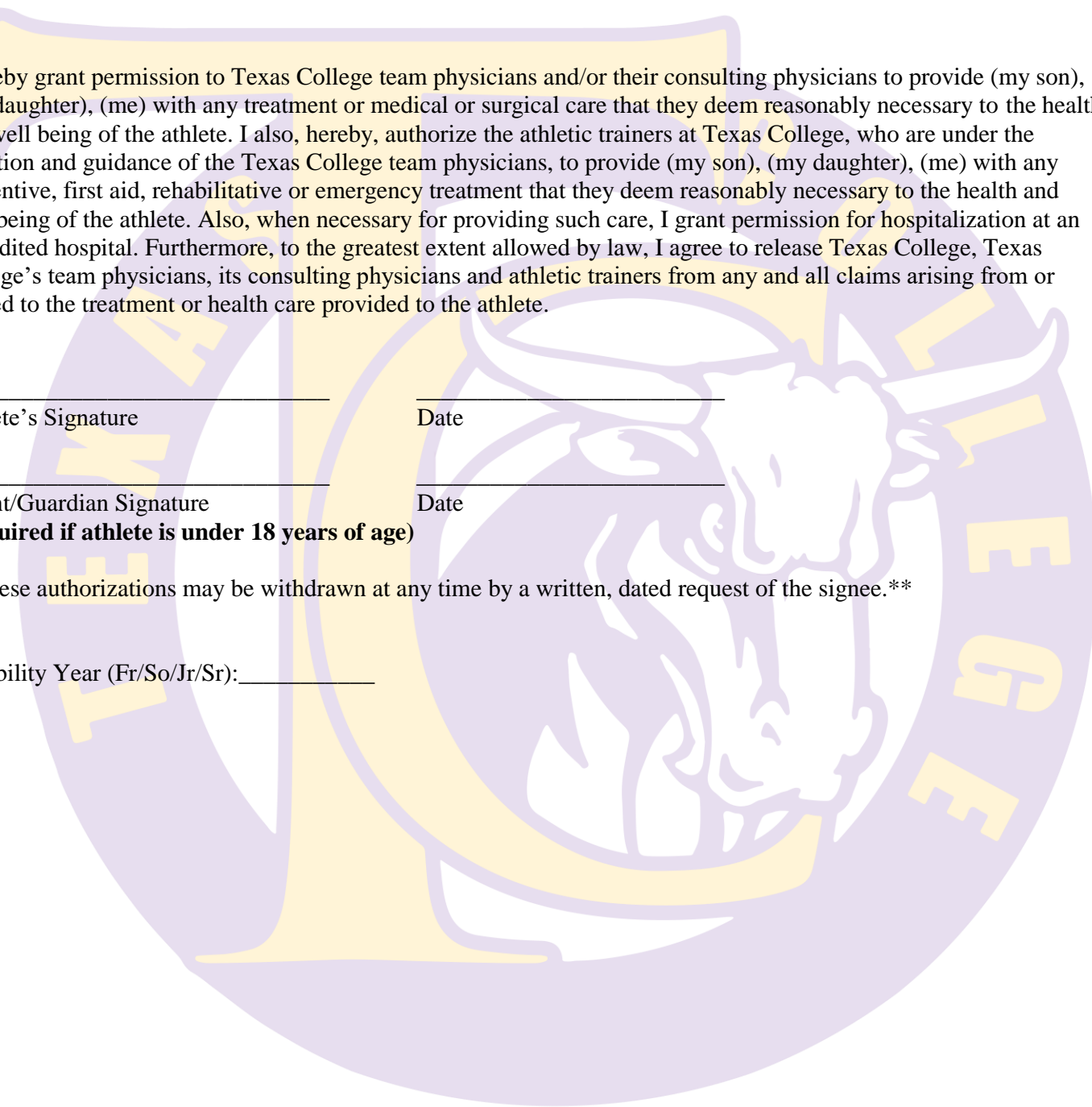
\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature  
**(Required if athlete is under 18 years of age)**

\_\_\_\_\_  
Date

**\*\*These authorizations may be withdrawn at any time by a written, dated request of the signee.\*\***

Eligibility Year (Fr/So/Jr/Sr): \_\_\_\_\_



2024-2025

**Form E**

Name \_\_\_\_\_

Sport \_\_\_\_\_

**Texas College  
Authorization for the Release of Medical Information  
To Coaches and Athletics Staff**

Student-Athlete: \_\_\_\_\_ Sport: \_\_\_\_\_

This authorizes the athletics trainers, team physicians, and sports medicine staff representing Texas College to release information concerning my medical status, medical condition, injuries, prognosis, and diagnosis related personally identifiable health information to the coaches, assistant coaches and other athletics staff. This information includes injuries or illnesses relative to past, present or future participation in athletics at Texas College.

The reason for this disclosure is to advise the coaches and athletics staff of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses so that they may make decisions regarding my athletic ability and suitability to compete while I am a student athlete. I understand that the entities that receive the information are not health care providers or health plans covered by federal privacy regulations, and that the information described above may be re-disclosed publicly and that the information will no longer be protected by those regulations.

I understand that Texas College will not receive compensation for its use/disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying in writing Texas College Sports Medicine Team Physician, but if I do, it will not have any effect on actions Texas College took in reliance on this authorization prior to receiving the revocation. This authorization expires six years from the date it is signed.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian  
(If student-athlete is under 18 years of age)

\_\_\_\_\_  
Date



2024-2025

**Form F**

Name \_\_\_\_\_

Sport \_\_\_\_\_

**Texas College**  
**Authorization for the Release of Medical Information**  
**to Parents or Guardian**

Student-Athlete: \_\_\_\_\_ Sport: \_\_\_\_\_

This authorizes the athletics trainers, team physicians, and athletics staff including coaches representing Texas College to release information concerning my medical status, medical condition, injuries, prognosis, and diagnosis related personally identifiable health information to my parents/guardian. This information includes injuries or illnesses relative to past, present or future participation in athletics at Texas College.

The reason for this disclosure is to advise my parents/guardian of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses so that they may assist me in making healthcare decisions while I am a student athlete. I understand that the entities that receive the information are not health care providers or health plans covered by federal privacy regulations, and that the information described above may be re-disclosed publicly and that the information will no longer be protected by those regulations.

I understand that Texas College will not receive compensation for its use/disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying in writing Texas College Sports Medicine Team Physician, but if I do, it will not have any effect on actions Texas College took in reliance on this authorization prior to receiving the revocation. This authorization expires six years from the date it is signed.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian  
(If student-athlete is under 18 years of age)

\_\_\_\_\_  
Date

## Texas College Sickle Cell Trait Waiver

Sickle Cell Waiver: Per NCAA rules, a prospective student-athlete that participates in a tryout must provide the institution with documented results of a sickle cell solubility test. If such documentation cannot be provided the prospective student-athlete must sign the written release declining the test below.

If the prospective student-athlete is under 18 at the time he/she signs this release the prospective student athlete’s parent/legal guardian must also sign the release. The completed release should be returned to the appropriate coach who must then submit it to the Office of Compliance.

**Facts About Sickle Cell Trait:**

- o Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- o Sickle cell trait is a common medical condition most predominate in those of African, Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, but people of all races and background may test positive.
- o Sickle cell trait is generally benign, and almost all of the 3 million Americans with sickle cell trait live healthy normal lives. However, during maximal exercise the oxygen levels in muscles can decrease sufficiently to cause some of the red cells to change from the normal disk shape to a crescent or sickle shape. These sickled red blood cells can block blood vessels in muscles, kidneys, and other organs resulting in severe damage to the involved tissues or elsewhere in the body and/or death.
- o Identification of sickle cell trait is not, by itself, a limiting or disqualifying finding with regards to athletic participation.

**Sickle Cell Trait Testing Protocol:**

Since 2010, the NCAA has recommended that all NCAA/NAIA student-athletes have knowledge of their sickle cell trait status. New requirements have been added to the pre-participation physical in which student-athletes must prior to any physical activity either:

1. Undergo a sickle cell solubility test,
2. Provide results of prior sickle cell testing, or
3. Complete Sickle Cell Trait Testing Waiver form

**SICKLE CELL TRAIT TESTING WAIVER**

I, \_\_\_\_\_, understand and acknowledge that the NCAA/NAIA and Texas College  
Student-Athlete Name, printed

Athletic Department recommends that all student-athletes have knowledge of sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts about sickle cell trait and sickle cell testing. 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 other disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to the Texas College Athletic Training staff.

I do not wish to undergo sickle cell trait testing and I voluntarily agree to release, discharge, indemnify and hold harmless Texas College, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the recommendation of the NCAA/NAIA and the Texas College Athletic Department.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student-Athlete Signature

Date

Sport(s)

Parent/guardian signature (if under 18)

Date