SANTA ROSA JUNIOR COLLEGE

Student Health Services

To: Student Athletes

From: Susan Quinn, Director, Student Health Services
Chad DeLaca, Medical Assistant/Community Health Worker, Student Health Services
Monica Ohkubo, Athletic Trainer

Date: 4/25/2018

Re: Fall 2018 Athletic Screenings and Physical Exams

Greetings Athlete!

All SRJC athletes are required to obtain medical clearance from the Student Health Services (SHS) department, prior to participating in SRJC athletics programs. Health screening and exam services are scheduled in the department specifically for each team, which you attend together. All athletes, new and returning, must attend the team's health screening. This includes any athlete choosing to have their physical exam portion of the screening performed by an outside provider prior to the screening date. **Please refer to the attached schedule to determine the date and time for your team's services.** These take place on the Santa Rosa Campus, in the Race Health Sciences Building – Room 4017.

Attached to this letter is a list of information that you need to collect, and forms to complete BEFORE the screening date for your team. Please review this and gather materials beforehand. Your coach will ask for these ahead of time.

Certain immunizations are required for athletic participation (as outlined on next page). If you need any of these vaccines, they can be obtained during your team screening, or by appointment, if needed. The Measles, Mumps and Rubella (MMR) vaccine costs $67 per dose and the Tetanus (Tdap) vaccine costs $34 per dose. The best way to avoid these costs is to start gathering your immunization records as soon as possible. If you are a returning athlete and would like to check on the status of your immunization records, please feel free to contact us at the telephone number below.

If you have any questions about the clearance process, please do not hesitate to call Student Health Services at (707) 527-4445. We look forward to seeing you this Fall and assisting however we can to assure a safe and successful season of sport!

FALL 2018 ATHLETIC SCREENINGS

FOOTBALL*

	Wednesday, August 1st, 2018	5:00 pm - (A-L)
	Thursday, August 2nd, 2018	5:00 pm - (M-Z)

***These screening sessions include the health history review (screening) and the MD exam.**

VOLLEYBALL

	Wednesday, August 8th, 2018	10:00 am - Screenings

SOCCER – Men*

(Men)	Wednesday, August 8th, 2018	2:00 pm – Screenings (returners only)
(Men)	Wednesday, August 8th, 2018	4:00 pm – Screenings (new athletes only)

SOCCER – Women*

(Women)	Monday, August 13th, 2018	1:30 pm – Screenings (returners only)
(Women)	Monday, August 13th, 2018	3:00 pm – Screenings (new athletes only)

WRESTLING*

	Monday, August 13th, 2018	4:30 pm – Screenings (returners only)
	Monday, August 13th, 2018	5:30 pm – Screenings (new athletes only)

WATER POLO

(Women)	Tuesday, August 14th, 2018	12:00 pm - Screenings
(Men)	Tuesday, August 14th, 2018	1:30 pm - Screenings

CROSS-COUNTRY

(Men/Women)	Tuesday, August 14th, 2018	3:00 pm – Screenings

MD exams for all contact* sports (*except football*) will be on **Wednesday, August 8th and Monday, August 13th after 5:30 pm (depending on which day your team is scheduled)**. You may be assigned an MD appointment at the time of your screening. **Please note: New contact sport and/or returning athletes with injuries may have to return later in the evening to see the MD for clearance.**

FALL 2018 ATHLETICS
ATHLETIC HEALTH CLEARANCE REQUIREMENTS CHECKLIST:

(See next page for additional information regarding requirements)

☐ **Completed Athletic Health History Form** (team screening) or completed **Athletic Health History and Exam Form** (if outside provider is doing the exam)

☐ **Completed Emergency Information Card** (pink)

☐ **Immunization Record** (proof of)*:

- 2 Measles, Mumps & Rubella (MMRs)
- 1 Tetanus or Tdap w/in the past 10 years

*Returning athletes may already have on file

☐ **Completed Athletic Authorization to Release Medical Info**

- Consent to Treat at bottom must also be signed

☐ **For Minors Only:**

- **All documents above must be signed by a parent or guardian** (except immunization records)
- **A Medical Consent for Treatment of a Minor Form** must be signed by a parent or guardian in order for the athlete to be seen by a health provider during the team health screening

PLEASE SUBMIT ALL DOCUMENTATION TO:

STUDENT HEALTH SERVICES
4017 RACE BUILDING
SANTA ROSA CAMPUS
(707) 527-4445 Phone
(707) 524-1858 Fax

2018 SRJC Athletic Participation Medical Clearance Requirements

PRE – SCREENING/ EXAM FORMS

all forms available at https://shs.santarosa.edu/downloadable-forms

New Athletes - Have not competed in a sport at SRJC:

- **Consent to Treat Form (**May sign digitally at Student Health Services [preferred], unless a Minor)
- **Immunization Records (see more information on requirements below)**
- **Health History Form** (or **Health History and Exam Form** – if outside provider.)
- **Emergency Information Form** (Includes health insurance policy information, unless uninsured.)
- **Authorization to Release Medical Information** (to Coaches, KAD staff, DRD, etc.)

Returning Athletes - Competed in a sport at SRJC; previously screened in SRJC Student Health Services:

- **Health History Form** (or **Health History and Exam Form** – if outside provider.)
- **Emergency Card** (Includes health insurance policy information, unless uninsured.)
- **Authorization to Release Medical Information** (to Coaches, KAD staff, DRD, etc.)

***MINORS**: A parent or legal guardian's signature is needed on a Minor Consent to Treat form, Authorization to Release Medical Information form, and the Emergency Information Form.*

IMMUNIZATION REQUIREMENTS

- **Two Measles, Mumps and Rubella vaccinations since birth, at least 1 month apart** (MMR)
- **One Tetanus vaccination w/in the past 10 years** (Tdap, DTap)

Acceptable forms of immunization records, i.e. places to look for these ahead of time.

- ✓ Yellow immunization cards w/vaccinations and medical providers, (parent/guardians may have)
- ✓ Medical records requested from your medical provider with immunizations received and dates
- ✓ Immunization records from public high schools attended.
- ✓ Immunization records can be faxed to Student Health Services at (707) 524-1858. Faxes must include student's name and team sport

What can I do if I can't find them in time before my team's screening and exam day? Options:

- ✓ Receive needed immunizations in Student Health Services at your team's screening and exam time, at a cost to you (charges posted to your student account)
- ✓ Receive needed immunizations at your personal healthcare provider's office or clinic
- ✓ Request more assistance in searching for your previous immunization records.
- ✓ A provisional medical clearance will be provided for athletes if their only thing pending is immunization requirements being met. Completion of either providing records, or receiving vaccinations will be required 8 weeks after the initial screening in Student Health Services.
- ✓ ***Costs of Immunizations in Student Health Services MMR = $67 TDaP = $34***

PHYSICAL EXAMS PERFORMED BY OUTSIDE HEALTHCARE PROVIDERS:

Exams by SRJC personnel are strongly preferred. Athletes may choose (at their own expense) to have the exam and screening performed by a personal health care provider. When chosen, the following conditions apply for an athlete to get medical clearance from SRJC:

- *The provider must use the SRJC Health History and Exam Form.*
- *The provider must be a physician or at a medical clinic (MD, NP, DO- no chiropractor).*
- *The exam must be no more than 1 month before the semester of competition.*
- *The athlete still needs to attend the team screening scheduled at Student Health Services for clearance.*

SANTA ROSA JUNIOR COLLEGE

SHS Medicat # _____

ATHLETICS PARTICIPATION HEALTH HISTORY

Athlete's Name: _____ **Sport:** _____

Student ID (Or SSN): _____ **Birth Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Health History TO BE COMPLETED BY THE STUDENT

Circle the number of any question to which you don't know the answer	Yes	No	If YES, explain with DATES
1. Has a doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have an ongoing medical condition (like diabetes or asthma)?			
3. Are you currently taking any prescription or nonprescription medicines or pills?			
4. Do you have allergies to medicines, pollens, foods or stinging insects?			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?			
7. Does your heart race or skip beats during exercise?			
8. Has a doctor ever told you that you have (check) ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection			
9. Has a doctor ever ordered a test for your heart? (example: EKG, echocardiogram)			
10. Has anyone in your family died for no apparent reason?			
11. Does anyone in your family have a heart problem?			
12. Has any family member / relative died of heart problems or of sudden death before age 50?			
13. Does anyone in your family have Marfan syndrome?			
14. Have you ever spent the night in a hospital?			
15. Have you ever had surgery?			

If you answer YES to any of the following questions (16-18) indicate the type of injury, next to the body part that was injured. Include the DATE of the injury and, if relevant, treatment done.

16. Have you ever had an injury, like a sprain, muscle or ligament tear, that caused you to miss a practice or game? Y ☐ N ☐

17. Have you had any broken or fractured bones or dislocated joints? Y ☐ N ☐

18. Have you had an injury that required x-rays MRI, CT, surgery, injections, rehab, physical therapy, a brace, a cast, or crutches? Y ☐ N ☐

Head: _____

Neck: _____

Shoulder: _____

Upper Arm: _____

Elbow: _____

Forearm: _____

Hand/Fingers: _____

Chest: _____

Upper Back: _____

Lower Back: _____

Hip: _____

Thigh: _____

Knee: _____

Calf/Shin: _____

Ankle: _____

Foot/Toes: _____

Athlete's Name_____SHS Medicat #_____

ATHLETICS PARTICIPATION HEALTH HISTORY….. Continued

Circle the number of any question to which you don't know the answer	Yes	No	If YES, explain with DATES
19. Have you ever had a stress fracture?			
20. Do you regularly use a brace or assistive device?			
21. Has a doctor ever told you that you have asthma or allergies?			
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
23. Have you ever used an inhaler or taken asthma medicine?			
24. Were you born without or are you missing a kidney, an eye, a testicle or another organ?			
25. Have you had mono within the last month?			
26. Do you have any rashes, pressure sores, or other skin problems			
27. Have you ever had a head injury or concussion?			
28. Have you been hit in the head and been confused or lost your memory?			
29. Have you ever had a seizure?			
30. Do you have headaches with exercise?			
31. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
32. When exercising in the heat, do you have severe muscle cramps or become ill?			
33. Has a doctor told you that you or a family member has sickle cell trait or sickle cell disease?			
34. Have you had any problems with your eyes or vision?			
35. Do you wear glasses, contact lenses, or protective eyewear, such as goggles or a face shield?			
36. Are you happy with your weight?			
37. Are you trying to gain or lose weight?			
38. Has anyone recommended you change your weight or eating habits?			
39. Do you limit or carefully control what you eat?			
40. Over the past few months, have you felt down, depressed or hopeless?			
41. Over the past few months, have you felt little interest or pleasure in doing things?			

PROVIDER'S NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information given is correct to the best of my knowledge.

_____ _____

Signature of Student-Athlete Date

(This form must be complete to be valid)

SANTA ROSA JUNIOR COLLEGE

Sport: ☐Men ☐Women _____
Fall: ☐Spring ☐ Fall Year: _____
Eligibility: ☐GS ☐RS ☐1st year ☐2nd year

Emergency Information Form

Note: ***This information will be used only in the event of any emergency. Your emergency contact person will not be notified unless you give your consent or are incapacitated and are unable to make medical decisions for yourself.***

Name: _____ Birth date: ____/____/_____ Age:_____ SID:_____

Local Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Email Address:_____

Are you covered under a health insurance policy? Yes _____ No _____ Is this policy an HMO or a PPO? _____

Name of the Policy Holder: _____

Name of Insurance Company: _____ Policy Number: _____

Group Name: _____ Group Number: _____

List any drugs or medications to which you have an **allergy** (e.g. penicillin) _____

_____

In Case of Emergency Notify:

1. Name _____ Relationship: _____

   Address: _____ City: _____ State: ____ Zip: _____

   Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

2. Name _____ Relationship: _____

   Address: _____ City: _____ State: ____ Zip: _____

   Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

ATHLETIC TRAINING ROOM CONSENT TO TREAT:

- I hereby authorize the Certified Athletic Trainers and sports medicine staff acting on behalf of SRJC to evaluate and treat any injury/illness that occurs as a result of my participation in intercollegiate athletics at SRJC. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses.
- I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission by the Team Physician, his/her delegate, or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment. *The team physicians of SRJC have the FINAL authority regarding participation status following injury/illness.*
- I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my Head Coach and the Certified Athletic Trainer. I also agree to adhere to the established injury management guidelines including rehabilitation and reassessment before I am released to return to full participation.
- This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

Signature _____ **Date** ____/____/_____

Student (Parent or Guardian if under 18 years of age)

Student's Name: _____ D.O.B.: _____

SANTA ROSA JUNIOR COLLEGE
STUDENT HEALTH SERVICES
Santa Rosa - Phone (707) 527-4445 FAX (707) 524-1858
Petaluma - Phone (707) 778-3919 FAX (707) 778-3901

ATHLETIC AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby voluntarily authorize the exchange of information between the following providers and/or the authorized representatives of the following agencies/organizations as indicated. I understand that if the organization/agency authorized to receive the information is not a health care provider; Federal Privacy Regulations may no longer protect the released information.

I give permission for an ongoing exchange, between SRJC Student Health Services (SHS) and the SRJC Kinesiology, Athletics & Dance Department (KAD), of all records that may pertain to Athletics clearance, illnesses and/or injuries and an ongoing informational exchange of health records with SRJC Disability Resources Department (DRD) as needed for academic accommodation.

SRJC Student Health Services Department (SHS)
1501 Mendocino Ave.
Santa Rosa CA 95401

SRJC Kinesiology, Athletics & Dance Department
Including, but not limited to:
Athletic Training Room staff, Coaches & Athletic Director
1501 Mendocino Ave.
Santa Rosa CA 95401

SRJC Disability Resources Department (DRD)
1501 Mendocino Ave.
Santa Rosa CA 95401

This exchange of information is for the purpose of providing effective evaluation, treatment and appropriate services. I understand that this authorization may be revoked in writing at any time, except on the following date or under the following condition(s): _____

Sensitive Information Release
Do not release any sensitive information related to AIDS and/or HIV infection or treatment for Alcohol and/or drug abuse.

I further understand that the information provided to Student Health Services is going to be kept CONFIDENTIAL and is protected by Federal Privacy Regulations. I also understand that Student Health Services is not responsible for any mishandling of my information by other agencies/organizations whom I have authorized the information released to.

Signed:
_____**Date:**_____
If athlete is a Minor, the Parent or Legal Guardian must sign Authorization to Release Information.

Print Name: ***Phone:***

AUTHORIZATION and CONDITIONS TO TREAT

I hereby authorize the health care providers at Student Health Services, and their agents or consultants, to perform diagnostic and treatment procedures that, in their judgment, may become necessary while I am at Santa Rosa Junior College. I understand that it is my responsibility to arrive at my appointments on time, and to cancel appointments, if necessary, with as much advance notice as possible. Failure to keep or cancel scheduled appointments may result in termination of services.

Signed_____**Date:**_____
If minor, parent or guardian must sign the Medical Consent for Treatment of a Minor form

SANTA ROSA JUNIOR COLLEGE

STUDENT HEALTH SERVICES

MEDICAL CONSENT FOR TREATMENT OF A MINOR

This form is designed to permit the Santa Rosa Junior College – Student Health Services to evaluate and treat your child until she or he reaches the age of 18 or sooner if revoked in writing. It allows our office to provide the following services at each visit without requesting verbal or written consent from you:

1. **Routine student health care. (For problems such as colds, minor injuries and illnesses, cuts requiring tetanus immunization, etc.)**
2. **Emergency care, first aid, and referral to local health facilities should an emergency situation arise while your child is on the SRJC campuses.**

If you have any questions regarding this form, you are welcome to call the Student Health Services office at (707) 527 – 4445 and talk to one of our Nurse Practitioners on duty.

Student's Name_____

Social Security _____

Date of Birth _____

(I) (We), the undersigned parent(s)/guardian(s) to _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical evaluation, diagnosis or treatment that may be rendered to said minor child under the general or special supervision of physician or surgeon licensed under the provisions of the California Medical Practice Act, whether such diagnosis or treatment is rendered at Santa Rosa Junior College – Student Health Services or at a licensed hospital, clinic, or doctor's office.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to render care which the staff of the SRJC Student Health Services in the exercise of their best judgment may deem advisable.

It is understood that in case of an emergency, reasonable efforts shall be made to contact the undersigned prior to rendering treatment to the patient, and that any of the above treatment will not be withheld if the undersigned cannot be reached.

This consent is given pursuant to the provisions of Section 25.8 of the California Civil Code.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____ _____ _____

Address City State Zip

Telephone where Parent/Legal Guardian can be reached:

Name: _____ Home _____ Work _____

(Please print)