2019
NON-TRADITIONAL SEASON OF SPORT (NTS) ATHLETICS HEALTH CLEARANCE REQUIREMENTS CHECKLIST

If a *Non-Traditional Season of Sport* athlete has been screened (cleared to participate) at SRJC w/in the past year with a team during the regular season, they will be considered a "*Returner*" and are only required to complete/submit an updated Emergency Card.

All new athletes MUST complete or provide the following forms:

☐ **Completed Athletic Health History and Exam Form**
(outside provider – MD or DO is doing the exam.
No NPs and **No** Chiropractors!)

☐ **Completed Emergency Information Form**

☐ **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**

PLEASE SUBMIT ALL DOCUMENTATION TO THE TAUZER GYM ATHLETIC TRAINING ROOM (OR YOUR TEAM'S COACH):

MONICA OHKUBO
TAUZER GYM ATHLETIC TRAINING ROOM
SANTA ROSA CAMPUS
(707) 521-9642 FAX

SANTA ROSA JUNIOR COLLEGE

ATHLETICS PARTICIPATION HEALTH HISTORY AND EXAM

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

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

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

Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____

TO THE STUDENT-ATHLETE GETTING THIS EXAMINATION

1) **Make an appointment for a physical exam** with a community provider at a physician or medical clinic (Physical Exams done by a Chiropractor are not acceptable).
2) **Complete the Health History part of this form** prior to your physical exam appointment.
3) **Attend your physical exam appointment.**

TO THE CLINICIAN COMPLETING THIS EXAMINATION

1) **Review the attached Health History** (that the student has already completed), and indicate disposition of pertinent posi-tives.
2) **Complete the physical examination.**
3) **Summarize findings** of the history and exam.

Health History

TO BE COMPLETED BY THE STUDENT-ATHLETE *BEFORE* THE PHYSICAL EXAM

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?			
18. Have you ever had surgery?			

(This form must be complete to be valid)

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?

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

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

Head: _____	Upper Back: _____
Neck: _____	Lower Back: _____
Shoulder: _____	Hip: _____
Upper Arm: _____	Thigh: _____
Elbow: _____	Knee: _____
Forearm: _____	Calf/Shin: _____
Hand/Fingers: _____	Ankle: _____
Chest: _____	Foot/Toes: _____

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?			

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

ATHLETICS PARTICIPATION HEALTH HISTORY AND EXAM

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

Immunization Review

To be eligible to compete on an athletic team at the SRJC an athlete must have records of two MMR vaccines since birth and a tetanus shot within the past ten years. If you can confirm the dates that this student has receive these vaccines you may enter those dates here.

MMR #1: _____ MMR #2: _____ Td/Tdap: _____

☐ The athlete elected not to receive any vaccinations today, did not bring any immunization records to the appointment, and I to not have any immunization records for the athlete at this office.

Screenings/ Vitals

Height and Weight:

Height: _____

Weight: _____

Blood Pressure & Pulse:

(To Clear: BP: 140/90 or less, Pulse: <100)

BP: _____

Pulse: _____

Urine Testing:

(To Clear: Protein: neg. or trace Glucose: neg.)

Protein: _____

Glucose: _____

Vision:

(To Clear: 20/40 or better in both eyes)

☐ Corrected ☐ Uncorrected

Left Eye: _____

Right Eye: _____

Both Eyes: _____

Physical Exam

Appearance	☐ Normal	☐ Abnormal: _____
Eyes/ears/nose/throat	☐ Normal	☐ Abnormal: _____
Hearing	☐ Normal	☐ Abnormal: _____
Lymph Nodes	☐ Normal	☐ Abnormal: _____
Heart	☐ Normal	☐ Abnormal: _____
Murmurs	☐ Normal	☐ Abnormal: _____
Rhythm	☐ Normal	☐ Abnormal: _____
Lungs	☐ Normal	☐ Abnormal: _____
Abdomen	☐ Normal	☐ Abnormal: _____
Skin	☐ Normal	☐ Abnormal: _____
Teeth	☐ Normal	☐ Abnormal: _____
Hernia	☐ Normal	☐ Abnormal: _____
Genitourinary *(males only)*	☐ Normal	☐ Abnormal: _____

Musculoskeletal Exam

Neck	☐ Normal	☐ Abnormal: _____
Back	☐ Normal	☐ Abnormal: _____
Shoulder/Arm	☐ Normal	☐ Abnormal: _____
Elbow/Forearm	☐ Normal	☐ Abnormal: _____
Wrist/Hand/Fingers	☐ Normal	☐ Abnormal: _____
Hip/Thigh	☐ Normal	☐ Abnormal: _____
Knee	☐ Normal	☐ Abnormal: _____
Ankle	☐ Normal	☐ Abnormal: _____
Foot/Toes	☐ Normal	☐ Abnormal: _____

(This form must be complete to be valid)

Health History and Exam Summary

Clarifications and recommendations if any:

Medical Clearance Status

☐ Full medical clearance to participate in SRJC's athletics program without restriction.

☐ Medical clearance to participate in SRJC's athletics program with the following restrictions:

☐ Medical clearance to participate in SRJC's athletics program is pending until student provides us with the following records, or this follow-up action is taken:

☐ No medical clearance to participate in SRJC's athletics program (see Exam Summary above).

Signature of clinician completing exam | Degree | Date

Name of clinician (Please print)

Clinic/Office stamp with address and phone number or business card required

For SRJC Student Health Services use only

_____ NSOS
_____ Traditional

_____ Information forwarded to NP/MD/TR
_____ Immunization records confirmed & entered
_____ Coach and Equipment room notified

(This form must be complete to be valid)