SANTA ROSA JUNIOR COLLEGE

Student Health Services

To: Student Athletes

From: Susan Quinn, Director Student Health Services
Juanita Dreiling, Health Services Assistant Student Health Services
Monica Ohkubo, Athletic Trainer

Date: 11/22/2017

Re: Spring 2018 Athletic Screenings and Physical Exams

Greetings Athlete!

All SRJC athletes are required to obtain clearance from the Santa Rosa Junior College (SRJC) Student Health Services Department, prior to participating in SRJC athletics programs. **Attached to this letter is important information that will help you to navigate the required paperwork and immunizations necessary for you to bring to your team's health screening date, to obtain athletic clearance. Please review this and gather materials beforehand.**

Team health screenings will take place at Student Health Services, on the Santa Rosa campus, in the Race Building - Room 4017. Please refer to the attached schedule of team screenings in this packet for your team's screening date and time.

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. Your Athletic Course Fee includes a charge to have an athletic health screening and exam done free of charge in Student Health Services at these designated times.

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. However, they are <u>not</u> covered by the Course Fee, or Health Fee, and charges apply. The MMR vaccine costs $67 per dose and the Tetanus (Tdap) vaccine costs $34. 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 Spring and assisting however we can to assure a safe and successful season of sport!

SPRING 2018
ATHLETIC SCREENINGS SCHEDULE

STUDENT HEALTH SERVICES
4017 RACE BUILDING
SANTA ROSA CAMPUS

EARLY PAPERWORK	Monday, January 8th, 2018	8:00am-11:00am
TRACK	Wednesday, January 10th, 2018	8:00am–11:00am (Men) 2:00pm-5:00pm (Women)
SOFTBALL	Thursday, January 11th, 2018	8:30am-10:00am
TENNIS	Thursday, January 11th, 2018	10:00am-11:30am
BASEBALL	Thursday, January 11th, 2018	12:30pm-5:00pm
SWIMMING	Friday, January 12th, 2018	9:00am-11:30am (Men)
	Friday, January 12th, 2018	1:00pm-3:30pm (Women)
GOLF	Friday, January 12th, 2018	3:30pm-5:00pm
MAKE UP DAY	Friday, January 19th, 2018	Call for Appointment

SPRING 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

Spring 2018 Athletic Participation Requirements

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

- **Health History Form** (or **Health History and Exam Form** – if outside provider.)
- **Emergency Card** (Includes health insurance policy information, unless uninsured.)
- **Consent Forms (**May sign digitally at Student Health Services [preferred], unless a Minor)
  - Consent to Treat
  - Authorization to Release Medical Information (to Coaches, KAD staff, DRD, etc.)
  - Notice of Privacy Practices (FERPA) – Acknowledgement only
- **Immunization Records**
  - Two Measles, Mumps and Rubella (MMR vaccinations since birth)
  - One Tetanus vaccination w/in the past 10 years (aka Tdap, DTap, Adacel, etc.)
  - See **Immunizations** section below for additional information and helpful tips.

Returning Athletes - Competed in a sport at SRJC and had health screen at Student Health Services with team:

- **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.)
- **Immunization Records – Confirm Student Health Services has current records on file.**
  - Two Measles, Mumps and Rubella (MMR vaccinations since birth)
  - One Tetanus vaccination w/in the past 10 years (aka Tdap, DTap, Adacel, etc.)

Minors - *Please note*: The Authorization to Release Medical Information, the Minor Consent to Treat, and the Emergency Card form each requires a parent or legal guardian's signature. These forms are included with the online packet for new players @ https://shs.santarosa.edu/downloadable-forms . They can also be picked up from Student Health Services or downloaded individually from the SRJC Student Health Services website.

Helpful Hints on Gathering Immunization Records:

Acceptable forms of immunization records are:

- Yellow immunization cards w/vaccinations that have been verified by a medical provider.
- Medical records from a medical provider of the immunizations received.
- Immunization records from public high schools.

Note: Immunization records can be faxed to Student Health Services at (707) 524-1858. **Faxes must include student's name and team sport**.

Requirements for Exams Performed by Outside Providers:

It is preferred that the athletic exam be performed by an SRJC provider. However, athletes may choose (at their own expense) to have the exam and screening performed by a personal health care provider. If this option is exercised, the exam must be done by a physician or medical clinic (**physical exams performed by a Chiropractor are not acceptable**) and all of the following conditions will still apply in order to be cleared to compete:

- The provider must use the SRJC Health History and Exam Form.
- The exam must be no more than 1 month before the semester of competition.
- The team screening must be attended at Student Health Services to verify 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: (Circle)Men's/Women's_____
☐Fall ☐Spring Year: _____
Eligibility: ☐GS ☐RS ☐1st year ☐2nd year

Emergency Information Card

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: _____ SSN#: _____-____-_____ Birth date: ____/____/_____ Age: _____

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:_____**DOB:**_____

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 Resource 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)