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, DO or NP is doing the exam, no Chiropractors!)

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

☐ **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)

PLEASE SUBMIT ALL DOCUMENTATION TO SHS (OR YOUR TEAM'S COACH):

STUDENT HEALTH SERVICES
4017 RACE BUILDING
SANTA ROSA CAMPUS
(707) 527-4445 Phone
(707) 524-1858 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) **Gather your official immunization records** to bring to your physical exam appointment.
4) **Attend your physical exam appointment.**
5) **Bring the completed forms in person to SRJC's Student Health Services department**, along with your immunization records, and minor consent form, if applicable (Make sure to identify yourself clearly to the front office staff, there are several forms for you to sign).

TO THE CLINICIAN COMPLETING THIS EXAMINATION

1) **Review the attached Health History** (that the student has already completed), and indicate disposition of pertinent positives.
2) **Complete the physical examination.**
3) **Summarize findings** of the history and exam.
4) **Review the student-athlete's immunization records** to see if they are current, and update as needed. For participation in SRJC's Athletics program, students must have completed two MMRs since birth and have had a Tetanus shot within the last 10 years.
5) **Indicate medical clearance status,** i.e. whether this student-athlete is clinically cleared to fully participate in the sport selected, or if there are restrictions or follow-up needed to assure his/her participation will be safe.

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)

Sport: ____________________________

☐**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: ______________________________ 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)

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