Monroe Community College
STATE UNIVERSITY OF NEW YORK

Health Services
1000 East Henrietta Road
Rochester, NY 14623

Dear New Athlete,

Congratulations and welcome to Monroe Community College Athletic Program. We are glad to have you as part of MCC's team! ***The NJCAA and Health Services requirements must be completed before practicing and playing on an MCC sport team to keep you healthy and safe.*** Ask your individual coach regarding practice start dates. **Here is a checklist to assist you in making sure you have completed all of these requirements to be a member of your MCC Sport team.**

Health History & Physical Exam Form for New Student Athletes:

Part 1: Student Health History (completed by athlete)

1.) **Page 2**: I have listed the sport I will be playing Yes_____
I have recorded my date of birth & M # & last 4 digits of SS#. Yes_____
I have recorded my current address Yes_____
I have checked if I live in the Residents Halls and which one. Yes_____
I have listed a phone number where I can be reached. Yes_____
I have included my physician's name & phone number. Yes_____
I have listed my emergency contact and phone number. Yes_____
I have listed my insurance information, **including ID number, A copy of the front and back of the card must be attached To your physical form**. Yes_____
****if you do not have insurance it can be purchased by going to http://www.ajfusa.com/ajfusa/help_college_students_user.php?ID=59 and click on the On Line Enrollment Form****

2.) P**age 3 & 4**: I have answered **all** questions on these pages and signed & dated. Yes_____

Part 2: Health Care Provider Physical Evaluation (completed by medical provider)

4.) **Page 5:** My name, last four digits of SS# / M#, sport & DOB are filled in. Yes_____
Two MMR's or proof of immunity to Measles, Mumps and Rubella is listed. Yes_____
I've had a Meningitis vaccine or signed a waiver refusing. Yes_____
My Td (Tetanus) is up to date **(within 10 years)**. Yes_____
I've had my vision tested and filled in. Yes_____
The medical provider has listed my allergies, current medications, and completed the physical exam. Yes_____
Medical recommendation is checked, with explanations given if indicated. Yes_____
Medical Provider has signed & dated physical. Yes_____
Physical has been completed **within 1 year** of start of season. Yes_____
*****I have returned the completed form to Health Services via mail/walk in, no faxes will be accepted***** Yes_____

Once received from the athletic department, a nurse will review all information and notify the athletic department when you are cleared for participation in your sport. Congratulations and best wishes for a safe, healthy, winning season!

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INTERCOLLEGIATE ATHLETE PHYSICAL FORM (1ST YEAR)

PURPOSE:

Completion of this form is required for practice or play on any athletic team at Monroe Community College under the guidelines of the National Junior College Athletic Association. All student-athletes participating in any one of the NJCAA certified sports must have passed a physical examination administered by a qualified health care professional licensed to administer physical examinations, PRIOR TO THE FIRST PRACTICE FOR EACH CALENDAR YEAR IN WHICH THEY COMPETE. FALL SPORT DEADLINE FOR COMPLETED PACKETS IS JULY 15TH AND SPRING SPORT DEADLINE IS AUGUST 15TH.

ATHLETES WILL NOT BE ALLOWED TO PARTICIPATE IN ANY TYPE OF ACTIVITY RELATED TO THEIR SPORT WITHOUT THIS COMPLETED FORM and HEALTH SERVICES MEDICAL CLEARANCE. THE CLEARANCE PROCESS TAKES 48 HOURS FROM THE TIME HEALTH SERVICES RECEIVES YOUR COMPLETED PHYSICAL .

INSTRUCTIONS:

Students are to complete pages 1, 2, 3 of this packet with signatures and dates on the forms where indicated. Physicians complete page 4 of physical exam, sign and date. ALL ENTRIES NEED TO BE IN INK.

All these forms must be completed and returned to HEALTH SERVICES for review and clearance prior to participation on the first day of practice.

Mail completed forms to: 1000 East Henrietta Road, Rochester, New York 14623
Attn: Health Services Department

For additional health physical forms go to:
WEB PAGE: http://www.monroecc.edu/depts/athletics/index.htm?a-zindex
Click on Health Services for Athletes, click Intercollegiate Athlete Physical (1st year)

Questions: Health Services
PHONE: (585) 292-2018
FAX: NO FAXES WILL BE ACCEPTED

Monroe Community College
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STUDENT HEALTH HISTORY FORM (To be completed by student)

TODAYS DATE:_____SPORT:_____

YEAR ENTERING COLLEGE: _____SEMESTER: Fall Spring Summer

STUDENT M00#:_____Last 4 of SS#:_____DATE OF BIRTH:_____

NAME: _____
Last First Middle initial

ADDRESS: _____
Street City State Zip Code

RESIDENTIAL HALL STUDENT: □ YES □ NO
HALL_____
PHONE: _____CELL PHONE: _____
E-MAIL_____

PRIMARY CARE PHYSICIAN: _____
ADDRESS: _____
Street City State Zip Code
PHONE:_____

EMERGENCY NOTIFICATION:
NAME: _____
RELATIONSHIP_____
HOME PHONE: _____CELL PHONE: _____

INSURANCE INFORMATION
The Athletic Department requires that you complete and sign this form as part of your athletic clearance eligibility to show proof of your insurance coverage and acknowledgement of risk and responsibility before participating in a sport. Participation will not be allowed until this form is signed and on file with the Athletic Office.

Please indicate below the type of health/accident insurance coverage you have to ensure that you are in compliance with College/Athletic policy:

____I have purchased and am covered by the Accident and Sickness Insurance Plan available through A.J. Flood Companies, Inc.
____ I am covered by my parent's health/accident insurance plan:

Insurance Company_____

Primary Policy Holder's Name_____

Policy #_____

____I am covered by my own personal health/accident insurance plan with:

Insurance Company_____

Policy #_____
IMPORTANT – YOU MUST ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

Monroe Community College
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ATHLETE Waiver, Consent and Warning Form
Read and sign in all three places

MEDICAL INFORMATION RELEASE WAIVER

I, _____ age_____ while participating in Monroe Community College intercollegiate athletics, give my consent for the team physician, sports medicine staff, and the Monroe Community College Department of Health Services to provide me with appropriate health care. I permit any health care provider I might see due to an injury or illness to share any and all related information with the team physician, sports medicine staff, health services, coaches, and my parents/guardians as appropriate. This information will remain confidential and is only to be used in order that they are properly informed about my condition and capabilities while I am participating as a student-athlete at Monroe Community College. Authorization of this form shall be considered valid for the duration of my intercollegiate career at Monroe Community College.

*_____ _____
Student Signature **Date**

*_____ _____
Parent/Guardian Signature (under 18) Date

INFORMED CONSENT

I understand that injuries can, and do, occur in athletic practice and competition. Such injuries can result in, but are not limited to, temporary or permanent disability, paralysis, or death to my opponent or myself. These injuries may occur with or without any intent to violate any rules of the specific event. All such injuries can not be prevented.

Improper or unauthorized alteration of any protective equipment is in violation of NJCAA rules and can contribute to injuries. Monroe Community College will issue any and all required protective equipment in full compliance with appropriate rules and regulations of the NJCAA or other governing bodies. Monroe Community College student athletes will only wear issued equipment, unless given written permission and approval by the Director of Athletics, or his/her designee.

By signing this form I understand the risks that are involved in participating in sport at Monroe Community College as well as ones that may cause harm due to illegal equipment.

*_____ _____
Student Signature **Date**

*_____ _____
Parent/Guardian Signature (under 18) Date

HELMET WARNING
Lacrosse, Ice Hockey, Baseball, Softball

Do Not use your helmet to butt, ram, or spear an opposing player, or use your helmet as a weapon. This is in violation of the rules, and can result in severe head, brain, or neck injuries, paralysis or death to you, and possible injury to your opponent.

There is a risk that these injuries may occur as a result of accidental contact without the intent to butt, ram, or spear another player.

No helmet can prevent all head and neck injuries a player might receive while participating in sports. By **signing** this form I understand the proper use of the equipment and the risks that are involved.

*_____ _____
Student Signature **Date**

*_____ _____
Parent/Guardian Signature (under 18) Date

Section 2 - Student Athlete Section ** to be completed by athlete**

ANSWER ALL QUESTIONS	YES	NO	If yes, EXPLAIN WITH DATES
1. Has a doctor ever denied or restricted your participation in sport for any reason?			
2. Do you have an ongoing medical condition? (ie: diabetes, asthma, seizures, autoimmune disease)			
3. List all medications both prescription and over the counter medications that you are taking.			
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? (circle as applicable)			DURING or AFTER
6. Have you ever had discomfort, pain, racing heart or pressure in your chest DURING or AFTER exercise?			DURING or AFTER
7. Has a doctor ever told you that you have high blood pressure, high cholesterol, or heart murmur?			
8. Has a doctor ever ordered a test for your heart?			ECG Echocardiogram
9. Does anyone in your family have a heart problem or Marfan Syndrome?			Heart Problem Marfan Syndrome
10. Has any relative died of heart problems or of sudden unexplained death before age 50?			Who: Age: Heart Condition:
11. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis that caused you to miss a practice or game**? (Circle and give dates)**			Head Neck Shoulder Upper arm Elbow Forearm Hand/Finger Chest Upper Back Lower Back Hip Thigh Knee Calf/shin Ankle Foot/toes
12. Have you had any broken or fractured bones, or dislocated joints? (which bone)			**Which bone:** **Date:**
13.Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?			Head Neck Shoulder Upper arm Elbow Forearm Hand/Finger Chest Upper Back Lower Back Hip Thigh Knee Calf/shin Ankle Foot/toes (**Circle & give dates)**
14. Do you regularly use a brace or assistive device?			
15. Has a doctor ever told you that you have asthma or allergies?			
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
17. Have you ever used an inhaler or taken asthma medicines?			
18. Were you born without or are you missing a kidney, eye, a testicle, or any organ?			
20. Have you had mononucleosis within the last month?			
21. Do you have any rashes, pressure sores, or other skin problems?			
22. Have you ever had a head injury or concussion?			When:
23. Have you ever had a seizure?			
24. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?			
25. Do you wear glasses or contact lenses?			
26. Are you trying to gain or lose weight?			
27. Has anyone recommended you change your weight or eating habits?			
28. Do you limit or carefully control what you eat?			
FEMALES ONLY			
28. Have you ever had a menstrual period?			
29. How old were you when you had your first period?			
30. How many periods have you had in the last year?			

I attest to the truthfulness of the above statements and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior altering substances.

ATHLETE SIGNATURE:_____ DATE:_____

STUDENT NAME:_____ M#_____ SPORT:_____

SECTION 3 – TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER

IMMUNIZATION SCREENING ***Required**

***1. MMR 1) 2)** ***3.TETANUS (within 10 years)_____**

***2. Meningitis vaccine within past 5 years** **#4. HEP B 1) 2) 3)**

1) 2)

OR Date Declined_____

ALLERGIES_____

MEDICATION & SUPPLEMENTS (LIST ALL) ☐ **NONE**

_____

_____

Height: _____ **Weight:** _____ **Blood Pressure**: _____/_____ **Pulse**:_____

Uncorrected Vision: **R ____/ ____ L ____/ ____ Corrected Vision: R ____/ ____ L ____/ ____**

AREA EXAMINED	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
HAND/SKIN	☐	☐	
HEAD/EYES	☐	☐	
EARS/NOSE/THROAT/MOUTH	☐	☐	
NECK/NODES	☐	☐	
CHEST/LUNGS	☐	☐	
CARDIOVASCULAR	☐	☐	
Carotid Arteries Neck Veins Apical Pulse Heart Murmurs Heart Size	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
ABDOMEN	☐	☐	
MUSCULOSKELETAL/EXTREMITY	☐	☐	
MUSCULOSKELETAL/SPINE	☐	☐	
NERVOUS SYSTEM	☐	☐	
GENITOURINARY	☐	☐	

MEDICAL RECOMMENDATION:

☐ **Cleared without restrictions for all sports participation.**

☐ **Cleared, with recommendations for further evaluation or treatment for:** _____

_____

☐ **Not cleared for: ____ All sports; ____ Certain sports:** _____

Reason:_____

_____

_____ _____

PHYSICIAN'S/HEALTH CARE PROVIDER (WITH TITLE) SIGNATURE **PRINT PHYSICIAN'S/HEALTH CARE PROVIDER LAST NAME/STAMP**

_____

PHYSICIAN'S ADDRESS **OFFICE FAX # (IF APPLICABLE)**

_____ _____

PHYSICIAN'S TELEPHONE NUMBER ***DATE OF EXAM (Must be within one year of entering program)***

RETURN TO: MONROE COMMUNITY COLLEGE HEALTH SERVICES DEPARTMENT
1000 EAST HENRIETTA RD. ROCHESTER, NY 14623 PHONE: 585-292-2018, FAX 585-292-3856