Monroe Community College
STATE UNIVERSITY OF NEW YORK

Dear Returning Athlete,

We are glad to have you back as part of MCC's team!

Submission of the following pages, completed in full, is required for participation in any capacity on a Monroe Community College athletic team under the guidelines of the National Junior College Athletic Association (NJCAA). **The NJCAA and MCC Health Services requirements must be approved by Health Services before your participation in the athletic program begins.** 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 exams prior to the first practice for each calendar year in which they compete. Ask your individual coach regarding practice start dates.

Athletes will not be allowed to participate in any type of activity related to their sport without medical clearance from Health Services. Please note, packets submitted after the deadline below risk clearance delays. You will be notified via your MCC email if you are cleared. **Incomplete and/or incorrect completion of the following forms may result in a processing delay and therefore a delay in your athletic clearance and participation**

Important: Return this packet to Health Services on or before: July 1st via:

- Student Health Services Portal / email healthservices@monroecc.edu / Fax: (585) 292-3856
- In-Person: Building 3 Room 165
- Mail: 1000 East Henrietta Rd., Building 3 Room 165, Rochester, NY 14623

Instructions: Please ensure the packet has been completed in its entirety before submitting. This includes the following:

Athlete Completes Section 1

- Student Demographic Information
- Student Athlete Section

These are fillable PDF forms. You can use your computer to complete most fields, and print to sign and date using **INK.** Forms with pencil will not be accepted and will be returned to student.

Physician Completes Section 2

- Physical Exam, Signed and Dated

A computer-generated, signed and dated copy of a sports physical may be substituted for Section 2. All physical exams are valid for one calendar year from date of last physical. Athletes are responsible for scheduling their annual physical and submitting to Health Services in order to remain eligible to play, practice and compete at MCC.

Section 1: Athlete to ensure list below is completed

_____I have listed the sport I will be playing
_____I have recorded my date of birth & M00#.
_____I have recorded my current address.
_____I have checked if I live in the Residents Halls and indicated which one.
_____I have listed a phone number where I can be reached.
_____I have included my physician's name & phone number.
_____I have listed my emergency contact and phone number.

Section 2: Physician to ensure below is completed, athlete to review for accuracy

_____Name, M00#, sport & DOB are filled in.
_____Two MMR's or proof of immunity to Measles, Mumps and Rubella
_____Meningococcal (MCV4) immunization in last five years or declination waiver signed.
_____Tetanus (Td or Tdap) date is within **past 10 years**
_____Vision tested and filled in.
_____Physician listed allergies, medications and completed physical exam
_____Medical recommendation has been selected, with explanation provided as needed.
_____Physician has signed and dated physical.
_____Physical has been completed **within 1 year** of start of season.

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Section 1: Demographic Information

Today's Date:_____ Year entering college:_____ Semester: Please Select

Last Name:_____First Name:_____MI:_____

Student M00#:_____ Date of Birth:_____ Age: _____ Sport: _____

Address:_____City:_____State:_____Zip Code:_____

Residential Hall Student: ◯ Yes ◯ No If Yes, Which Residence Hall:_____

Cell Phone: _____ Email Address:_____

Primary Care Physician:_____

Physician Address:_____ Physician 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 acknowledgment 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, and you have provided a copy of the front and back of your insurance card.

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

COVID-19 History

Have you been previously diagnosed with COVID-19? ◯ Yes ◯ No **If yes, date of diagnosis:**_____

Physician Name/Address/Phone Number: _____

Please list any countries/states/cities you have traveled to in the last 30 days.

Destination(s): _____ Date(s): _____

Section 1: Student Athlete Section

Athlete – Please answer all questions.

1. Has a doctor ever denied or restricted your participation in sport? ◯ Yes ◯ No
   If yes, please explain with dates: _____
2. Please list any ongoing medical conditions such as diabetes, asthma, seizures?
   _____
   _____
3. List all medications (prescribed and over the counter) that you take:
   _____
   _____
4. Please list any allergies: _____
   _____
5. Were you born without, or are you missing, a kidney, eye, a testicle, or any organ? ◯ Yes ◯ No
   If yes, please explain: _____
   _____
6. Have you had mononucleosis within the last 6 weeks? ◯ Yes ◯ No
7. Do you have any rashes, pressure sores, or other skin problems? _____
8. Have you ever had a head injury or concussion? ◯ Yes ◯ No
   If yes, please explain with dates: _____
9. Has a doctor told you that you or a family member has sickle cell trait or sickle cell disease? ◯ Yes ◯ No
   If yes, please explain _____
10. Do you wear glasses or contact lenses? ◯ Yes ◯ No
11. Are you trying to gain or lose weight? ◯ Yes ◯ No
12. Has anyone recommended you change your weight or eating habits? ◯ Yes ◯ No
13. Do you limit or carefully control what you eat? ◯ Yes ◯ No
14. Have you ever passed out, or nearly passed out, during or after exercise? ◯ Yes ◯ No
    If yes, please explain with dates: _____
15. Have you ever had discomfort, pain, racing heart or pressure in your chest during or after exercise?
    ◯ Yes ◯ No If yes, please explain with dates: _____
16. Has a doctor ever told you that you have high blood pressure, high cholesterol, or heart murmur?
    ◯ Yes ◯ No If yes, please explain with dates: _____
17. Has a doctor ever ordered a test for your heart and, if so, why:
    _____
    _____

Student Signature: _____ Date: _____

Parent Signature (if under 18): _____ Date: _____

18. Does anyone in your family have a heart problem or *Marfan's Syndrome*? ◯ Yes ◯ No

    If yes, what problem? _____

19. Has any biological relative died of heart problems or of sudden unexplained death before age 50?

    ◯ Yes ◯ No If yes, please explain who, and what condition they had if known:

    _____

20. Do you cough, wheeze, or have difficulty breathing during or after exercise? ◯ Yes ◯ No

    If yes, please explain: _____

21. Have you ever used an inhaler or taken asthma medicines? ◯ Yes ◯ No

    If yes, please explain with dates: _____

22. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis that caused you to miss a practice or game? ◯ Yes ◯ No

    If yes, please explain with dates:

    _____

23. Have you had any broken or fractured bones or dislocated joints? ◯ Yes ◯ No

    If yes, please explain with dates: _____

24. 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? ◯ Yes ◯ No

    If yes, please explain with dates:

    _____

25. Do you regularly use a brace or assistive device? ◯ Yes ◯ No

    If yes, please explain: _____

Females Only

- Have you ever had a menstrual period? ◯ Yes ◯ No
- How old were you when you had your first period? _____
- How many periods have you had in the last year? _____
- If less than monthly, is it caused by your form of birth control? ◯ Yes ◯ No

All Students

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.

Student Signature: _____ Date: _____

Parent Signature (if under 18): _____ Date: _____

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Section 2: Sports Physical Exam

To Be Completed by Health Care Provider. An EMR Generated Sports Physical May Be Substituted

Student's Name:_____DOB:_____Sport:_____

Required Immunizations

- MMR: #1)_____#2) _____
- Meningitis ACWY vaccine within past 5 years of college entry:_____
- Tetanus (within past 10 years) _____
- COVID-19 Vaccine: #1) Manufacturer: _____ Date: _____
  #2) Manufacturer: _____ Date: _____
  Booster: Manufacturer: _____ Date: _____

History of COVID-19? Yes No **If yes, complete Post COVID Evaluation on Page 6.**

Allergies:_____

Medications & Supplements: None or_____

History of Heart / Lung / Kidney / Autoimmune Disease / Diabetes / N/A / Comment: _____

Height:_____Weight:_____Blood Pressure:_____/_____Pulse:_____

Uncorrected Vision: R_____/_____L_____/_____ Corrected Vision: R_____/_____L_____/_____

Area Examined	Check Below if Normal	Describe Abnormal Findings
• Hand/Skin	_____	_____
• Head/Eyes	_____	_____
• Ears/Nose/Throat/Mouth	_____	_____
• Neck/Nodes	_____	_____
• Chest/Lungs	_____	_____
• Cardiovascular	_____	_____
○ Carotid Arteries	_____	_____
○ Neck Veins	_____	_____
○ Apical Pulse	_____	_____
○ Heart Sounds	_____	_____
• 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:_____

Health Care Provider's Signature or Stamp (With Title): _____
Date (Must be within 1 year): _____Print Health Care Provider's Last Name: _____
HCP's Address: _____
Office Phone #:_____Office Fax #:_____

Return to: Monroe Community College - Health Services Department 1000 East Henrietta Road, Rochester, NY 14623 (585) 292-2018 Fax (585) 292-3856

History of COVID-19 (Circle): Yes No

If Yes, Onset Date: _____ Start Date of Isolation: _____

Systemic Symptoms for 1 or More Week (Fever, Myalgia, Chills, Profound Lethargy): Yes No

Hospitalization Due to COVID Symptoms Yes No

ICU Hospitalization, Intubation or Evidence/Diagnosis of MIS-C: Yes No

Chest Pain, S.O.B., Palpitations Present Yes No

Cardiology Referral Indicated: Yes No

Cleared without restrictions post COVID-19: Yes No

Post COVID 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: _____

_____

_____

Health Care Provider's Signature or Stamp (With Title): _____

Date (Must Be Within 1 Year): _____Print Health Care Provider's Last Name: _____

HCP's Address: _____

Office Phone #: _____ Office Fax #: _____