Monroe Community College
STATE UNIVERSITY OF NEW YORK

Health Services
1000 East Henrietta Road
Rochester, NY 14623

Academic Year- Fall 20___/Spring 20____

Dear Returning Athlete,

Welcome back 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.**

Returning Athlete forms:

Part 1: Student Health History (completed by athlete)

Page 1:	I have listed the sport I will be playing	Yes_____
	I have recorded my name, date of birth, SS# and M#	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****	
	I have listed my current medications	Yes_____
	I have listed all allergies	Yes_____
Page 2:	I have answered **all** questions on this page and signed & dated the form at the bottom.	Yes_____

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

Page 3:	My name, and M# and Sport is filled in.	Yes_____
	The medical provider has 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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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

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?			Head Neck Shoulder Upper arm Elbow Forearm Hand/Finger Chest Upper Back Lower Back Hip Thigh Knee Calf/shin Ankle Foot/toes **(Circle & give date)**
12. Have you had any broken or fractured bones, or dislocated joints?			What 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 date)**
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

ALLERGIES_____

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

_____

_____

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

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

Meningitis vaccine within past 5 years #1) _____ **# 2)**_____ **OR**
Date Declined_____

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