SMCCCD Pre-Participation Sports Screening Directions

Dear Student / Guardian & Physician,

Welcome to the athletics program offered through the San Mateo Community College District. Before being able to practice or compete with any of our teams, students are required to complete and pass a pre-participation sport screening. The screening must be signed off and certified by a MD or DO. Screenings signed off and certified by Nurse Practitioners, Physician's Assistants, Chiropractors or Acupuncturists or any other health care practitioner will not be accepted. Your screening must be completed within 6 months of the first scheduled day of practice and is valid for one calendar year. This screening is not a substitute for a regular physical exam by your family doctor. The purpose of the exam is to enable the Sports Medicine staff at our colleges to best serve the needs of the student so he / she can participate safely and effectively.

The screening form consists of eight pages. You need to take your time and make sure that you complete all the information as completely and accurately as possible. It is also important that the physician performing the screening do the same. To help you the student/ guardian and the physician performing the screening, here are some helpful directions below. Please show these to your physician:

Student / Guardian

- At the top of all four pages, please make sure that you print neatly your last name, first name, G number and the sport you are playing. Your G number is your registration number assigned to you by the San Mateo Community College District when you applied. If you do not remember your G number, it can be located on websmart. If you do not have a G number yet, please leave this portion blank.
- Please take your time and answer all the questions. You should either check Yes or No for the questions asked. If you check yes, you will need to further explain your response in the space provided. Failing to answer all the questions, will result in you not being able to practice or compete in a timely manner.
- On page 1 through 3, you need to fill out and answer all the questions listed on that page.
- At the bottom of the Page 3 sign and date certifying that all the information on all the pre-participation sports screening exams forms, you have filled out, including my family medical history, my medical and musculoskeletal history are complete and accurate to the best of your knowledge. If you are below 18 years of age, your parent or guardian must sign and date as well.
- On Page 4, you need to provide your name, G number (if possible) and sport. **Do not complete Page 4.**

Physician (MD or DO)

- After reviewing the Medical and Musculoskeletal History information located on pages 1 through 3, please perform the medical and musculoskeletal examination on Page 4 giving details in the space to the right if anything is abnormal or noteworthy.
- Please note any findings and then check the box with the appropriate medical and musculoskeletal disposition. You would then need to **print and sign your name along with the date at the bottom of the form. Also, please check the box indicating if you are a MD or DO and have your office stamp placed at the bottom of the form.**

After completing the screening, the student should return all eight pages to the certified athletic trainer. If the student wants a copy of the screening exam, they should make a photocopy before submitting the originals. Please do not give a screening form to your coach. Thanks in advance for your diligence in completing this process.

SMCCCD Pre-Participation Sports Screening

This is not a substitute for a regular physical exam by your family doctor

Print Last Name _____ Print First Name _____ G# _____ Sport _____

This Exam must be signed off by an MD or DO

Exams signed off by any other health care professional will not be accepted!

Students complete page 1 and 2 of this sports screening exam. All questions must be answered.

MD or DO must complete and sign page 3 of this sports screening exam.

1. FAMILY MEDICAL HISTORY: Check "Yes" or "No" for all questions and explain all "Yes" responses in the space provided.

☐Yes ☐No Has anyone in your family ever died for no apparent reason? Relationship to you: _____

☐Yes ☐No Has any family member/blood relative died of heart problems or of sudden death before age 50? Relationship to you ____

☐Yes ☐No Does anyone in your family have any heart problems, conditions (i.e. hypertrophic cardiomyopathy, dilated cardiomyopathy, Long QT syndrome, Marfans' syndrome, Cardiac Arrythmias) or has had heart surgery? Explain _____

_____

2. ATHLETE'S MEDICAL HISTORY: : Check "Yes" or "No" for all questions and explain all "Yes" responses in the space provided.

When was your last physical exam that included blood pressure and a doctor listening to your heart & lungs? Date _____

☐Yes ☐No Have you ever had a medical illness, injury, or surgery that kept you from participating in practice or competition?
If Yes, explain: _____
Injury/Illness/Surgery was: _____ Year_____Time missed: Days ___ Weeks ____Months _____

☐Yes ☐No Were you born without or are you missing any of the following? ___ Kidney ___ Eye ___ Testicle ___ Other Organ

☐Yes ☐No Are you allergic to: ___ Foods _____ Stinging Insects _____ Environmental Agents/Pollen ____ Medication _____

☐Yes ☐No Have you ever had to stay overnight in the hospital as a patient? Explain _____

☐Yes ☐No Have you ever had any surgery for any medical condition? Explain _____

☐Yes ☐No Have you ever passed out or nearly passed out **during** exercise? Why? __ Medical Illness ___Conditioning __ Heat

☐Yes ☐No Have you ever passed out or nearly passed out **after** exercise? Why? ___ Medical Illness ___Conditioning ___ Heat

☐Yes ☐No Do you get more easily tired or fatiqued than your teammates during or after exercise? __ Med Illness __ Cond __Heat

☐Yes ☐No Have you ever had chest discomfort, pain or pressure during exercise? ___Mild Exercise Moderate Ex. ___ Strenous Ex

Has a doctor ever asked that you complete, or have you had, any of the following tests:

Yes	No	Test	Requested	Completed	Year	For what reason?
		X-Ray				
		MRI				
		CT Scan				
		Bone Scan				
		EMG (Nerve Test)				
		EKG (Heart test)				
		Stress EKG				
		Echocardiogram				
		Stress Echocardiogram				
		Halter Monitor				

Yes	No	Medication/Supplement Use	Name of Medication	Reason/Condition		Name of Medication	Reason/Condition
		Over-the-counter Medications					
		Prescription Medications					
		Prescribed Creams/Ointment					
		Inhalers					
		Supplements for Weight Gain					
		Supplements for Weight Loss					
		Anabolic Steroids/HGH					

Yes No Do you use or have you ever used recreational drugs? ___ Daily ___1x/week ___< 1x/week ___1x/month

Yes No Do you or have you ever consumed alcoholic drinks? ___ Daily ___ 1x/week ___<1x/week ___ 1x/month

Yes No Do you use tobacco? ___ Cigarettes ___Cigars ___ Smokeless Dip/Chew __Daily __1x/wk __<1x/wk __1x/mo.

Print Last Name _____Print First Name _____G# _____ Sport _____

YES	NO	WOMEN ONLY	
		Have you been pregnant?	Year(s)
		Are you pregnant now?	How many months?
		Date of first menstrual cycle	Month _____ Year _____
		Longest time between periods	Days _____ Months _____
		No periods since:	Month _____ Year _____
		Menstrual irregularity / cramps	Medication _____
		Are you taking Birth Control Pills	

2a. ATHLETE'S MEDICAL HISTORY – Have you ever had any of the following symptoms?

Yes	No	Year	Symptoms		Yes	No	Year	Symptoms
			Dizzyness					Chest Pain
			Fainting/Near Fainting					Shortness of Breath
			Chest Tightness/Pressure					Wheezing
			Irregular Heart Beats					Headaches
			Abdominal Pain					Heart Skips Beats

2b. ATHLETE'S MEDICAL HISTORY – Have you ever had any of the following conditions?

Yes	No	Year	Condition		Yes	No	Year	Condition
			Rhumatic Fever					Asthma / Exercise Induced Asthma
			Mononucleosis					Bronchitis
			Jaundice					Pneumonia
			Cancer					Pneumothorax
			Kidney Disease					
			Thyroid Disease					Heart Murmur
			Thyroid Disease					Cardiomyopathy
								Marfan's Syndrome
			Heat Cramps/Illness					Sickle Cell: Disease ___ Trait ___
			Dehydration					Heart Infection - Myocarditis
			Heat Exhaustion/Stroke					Hemophilia
								Anemia
			Crohn's Disease					High Blood Pressure
			Bladder/Bowel problems					HIV ___ Aids ___
			Anorexia/Bulimia					High Cholesterol
			Ulcers					Diabetes: Type 1 __ Type 2 __
			Apendicitis/Apendectomy					Blood Sugar: High ___ Low ___
			Hernia					Hepatitis: A ___ B ___ C ___
			Impetigo					Visual Impairment
			Herpes Zoster					Hearing Impairment
			Herpes Simplex (cold sores)					
			Tinea Corporis (ringworm)					Concussion or Knocked Out
			Tinea Cruris (jock itch)					Migraine Headaches
			Tinea Pedis (athletes foot)					Epilepsy
			Folliculitis					Seizures
			MRSA					

Print Last Name _____ Print First Name _____ G# _____ Sport _____

YES	NO	Don't Know	IMMUNIZATION RECORD	Year
			Tetanus	
			Hepatitis A	
			Hepatitis B	

Please list all medical illness or conditions that kept you from participating in any practice or competition, what year, time lost, and outcome:

Condition	Year	Time Lost	Outcome

3. **ATHLETE'S MUSCULOSKELETAL HISTORY:** Have you **ever** had any of the following?

Yes	No	Year	Injury		Yes	No	Year	Injury
			Muscle Strain/Pull					Head Injury
			Ligament Sprain/Injury					Neck Pain/Injury
			Deep Bruise/Contusion					Upper Back Pain/Injury
			Fracture					Lower Back Pain/Injury
			Stress Fracture					Rib or Chest Pain/Injury
			Nerve Injury/Stinger					Shoulder Pain/Injury
			Meniscus Injury					Elbow Pain/Injury
			Cartilage Injury					Forearm Pain/Injury
			Labral Injury					Wrist Pain/Injury
			Tendonitis/Tendinopathy					Hand Pain/Injury
			Shin Splints					Finger Pain/Injury
								Thumb Pain/Injury
			Surgery					Hip Pain/Injury
			Numbness due to injury					Thigh Pain/Injury
			Weakness due to injury					Knee Pain/Injury
								Lower Leg Pain/Injury
			Crutches					Ankle Pain/Injury
			Splint/Sling					Foot Pain/Injury
			Brace					Toe Pain/Injury

Please list all injuries that kept you from participating in any practice or any competition?

Injury	Year	Time Lost	Outcome

I certify that all the information I have completed regarding Family Medical History, Athlete's Medical History, Medication/Supplement Use, Immunization Record, and Musculoskeletal History is complete and accurate to the best of my knowledge.

Athlete's Signature _____ Date_____

Parent's Signature (if athlete is a minor under 18 years) _____ Date_____

Print Last Name: _____ First Name_____ G#_____ Sport:_____

MD or DO must certify and sign off this section. Doctor, please check each item with your finding and provide a final disposition at the bottom of the form.

4. MEDICAL EXAMINATION Check each item giving details in space to right if abnormal or noteworthy.

Medical Examination	Normal	Abnormal
1. Blood Pressure (Seated) Systolic_____/_____ Diastolic		
2. Resting Heart Rate (required) BPM:		
3. Eye Test (required) Left Eye: 20/ Right Eye: 20/		Vision tested with ☐Contact Lenses ☐Glasses
4. Height: _____' _____" Weight:_____		
5. General Appearance (fitness, body fat)		
6. HEENT (pupils, ears, eyes, nose, mouth, teeth, throat)		
7. Chest (chest wall and breath sounds)		
8. Cardiac auscultation supine and standing (murmur)		
9. Cardiac (Pulses and rhythm)		
10. Abdomen (liver, spleen, masses)		
11. Skin (rash, jaundice)		
12. Neurologic (CNS, DTR's, sensations)		
13. Geniturinary (male only: hernia, testes)		
14. BMI: _____ or % BF: _____ (Optional)		

5. MUSCULOSKELETAL EXAMINATION: Check each item giving details in space to right if abnormal or noteworthy.

Musculoskeletal Exam: (Grade abnormal joint laxity tests on a 0-3+ scale)	Normal	Abnormal
1. Spine (deformity, tenderness, motion, strength, stability)		
a. Cervical (facet dysfunction, disk injury, radiculopathy, stingers)		
b. Thoracic (kyphosis, scoliosis)		
c. Lumbar (spondylolysis, spondylolisthesis, facet dysfunction, disk injury)		
2. Upper Extremity (deformity, tenderness, motion, strength, stability)		
a. AC/ SC Joint/Clavicle (AC separation, clavicle dislocation/instabillity)		
b. Shoulder (rotator cuff, labrum, instability, impingement)		
c. Elbow (UCL tears, tendonitis, loose bodies, Little League elbow)		
d. Wrist (carpal tunnel, tendinitis, instability)		
e. Hand		
f. Thumb (De Quervain's, instability, tenderness, motion)		
g. Fingers (Mallet or Jersey Finger, Swan Neck or Boutineer Deformity		
3. Lower Extremity (deformity, tenderness, motion, strength, stability)		
a. Hip (deformity, joint pain, range of motion, hip flexors, labrum)		
b. Leg (Hamstrings, Quadriceps)		
c. Knee (MCL, LCL, ACL, PCL, Meniscus)		
d. Lower leg (MTSS, Achilles Tendon)		
e. Ankle (talar tilt, anterior drawer)		
f. Foot (supination, pronation, pes cavus, pes planus)		
g. Toes (hallux valgus, hammer toes, bunions)		

Finding/Problems	Recommendations (Prevention/Treatment)
1	
2	
3	

MEDICAL AND MUSCULOSKELETAL DISPOSITION

_____ Cleared for collision/contact/non-contact sports

_____ Conditional Participation, limited to: _____

_____ No participation until:_____

_____ No participation in any sport because of:_____

****Physician's Signature Required: _____ Date: :_____/_____/_____**

Print Physician's Name:_____

Physician's Phone if not on office stamp: ( ) -

M.D. Office Stamp Required

SMCCD Emergency Contact Information/Health Insurance Form

(* Athlete completes & signs form. Parent/Legal Guardian must sign as well if student is under 18 years of age)

Print Name: Last_____ First _____ Date of Birth : _____ - _____ - _____

Health Insurance (circle one): ☐ None or ☐ I am covered by the following policy:

Insurance Company:_____ Policy #_____ Group #_____

Insurance Company Address: _____

City:_____ State:_____ ZIP:_____

Insurance Company Phone: _____ Medical Group Name:_____

Policy is: ☐ HMO ☐ PPO ☐ Indemnity (I can go to any doctor) ☐ Medi-Cal /Health Families

Policy Holder is: _____ Date of Birth of Policy Holder: _____ / _____ /_____

If HMO, Assigned Physician:_____ M.D. Phone:( ) _____ - _____

I give permission for the following services listed below if ill or injured while competing or practicing with a San Mateo Community College District, here after referred to as SMCCD, athletic team.

1. The Sports Medicine Staff and volunteers of SMCCD or the institution that is hosting a visiting event or match to provide injury assessment, treatment and rehabilitation.
2. EMS for transportation and emergency care to the hospital.
3. The attending physician at the hospital to provide emergency services.

I have attended /received "Sports Medicine Orientation" for student athletes and fully understand what my rights are and services are available to me concerning assessment, treatment and rehabilitation for any injuries/illness' sustained while participating in athletics and appropriate use of the SMCCD athletic injury insurance.

I understand, acknowledge and agree that the SMCCD, it's employees, officers, agents, or volunteers shall not be liable for any injury/illness/death suffered by me which is incident to and/or associated with preparing for and or participating in athletic activities or transportation to or from said activities in a district owned van or bus.

I understand and acknowledge that SMCCD and the school's insurance are not responsible for injuries sustained in activities not sponsored by the SMCCD or not properly reported to the sports medicine staff. All injuries must be reported immediately, documented and kept on file by the sports medicine staff.

I understand and acknowledge that the SMCCD has limited insurance coverage which is secondary to all other policies that a student is covered for. Bills for services which are not paid by insurance are the responsibility of the student/parent/guardian.

I understand and acknowledge that filing a claim for benefits with the school athletic injury insurance for injuries not incurred while practicing or competing as an intercollegiate athlete for the SMCCD is considered insurance fraud under the law. I also understand that filing for benefits with the school athletic injury insurance when I am covered by my own personal insurance policy for such benefits is also considered insurance fraud under the law. Any person who knowingly and with the intent to defraud any insurance or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning facts material thereto, has committed a fraudulent act, shall withdraw from any sports activities and is subject to disciplinary action by SMCCD.

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I acknowledge that I have carefully read this SMCCD Sports Medicine Emergency Contact/Insurance Form and that I understand and agree to its terms.

I hereby certify under penalty of perjury that foregoing the information given on these forms is truthful, complete and correct to the best of my knowledge. I hereby certify that I have no other health insurance other than what is listed on this form.

Signature_____ Date_____/_____/_____

Signature: _____ Date _____/_____/_____

(Parent/Guardian's signature if athlete is under 18)

SMCCD Emergency Contact Information/Health Insurance Form

(* Athlete completes & signs form. Parent/Legal Guardian must sign as well if student is under 18 years of age)

Print Name: Last _____ First _____Sport _____

Student ID #: **G** ____ ____ ____ ____ ____ ____ ____ ____ *(do not enter your social security number)*

Address: _____ Email: _____

City: _____ State:_____ Zip:_____

Phone Home: ( )_____ - _____ Cell/Pager: ( )_____ - _____

Employment Status: ☐Unemployed or ☐Employed Work Phone: ( )_____ - _____

Employer Name & Address: _____

City: _____ State: _____ Zip:_____

Emergency Contact Person:_____ **Cell** Phone: ( )_____ - _____

Relationship to you ☐friend ☐relative **Home or work** Phone: ( )_____ - _____

Mother/Spouse/Partner/Legal Guardian's Name:_____
Last First

If you **did not** list a Mother/Spouse/Partner/LegalGuardian please check the correct box: ☐Deceased ☐Unknown

Father/Spouse/Partner/Legal Guardian's Name:_____
Last First

If you **did not** list a Father/Spouse/Partner/Legal Guardian please check the correct box: ☐Deceased ☐Unknown

Parent/Spouses' Address & Phone Number (if different than yours):

Address: _____

City: _____ State:_____ Zip:_____

Phone Home: ( )_____ - _____ Cell/Pager: ( )_____ - _____

Mother/Spouse/ Partner/Legal Guardian's Employment Information ☐Check box if work is same as home address

Employment Status: ☐Unemployed or ☐Employed Work Phone: ( )_____ - _____

Employer Name & Address: _____

City: _____ State: _____ Zip:_____

Father/Spouse/ Partner/Legal Guardian's Employment Information ☐Check box if work is same as home address

Employment Status: ☐Unemployed or ☐Employed Work Phone: ( )_____ - _____

Employer Name & Address: _____

City: _____ State: _____ Zip:_____

Signature_____ Date_____/_____/_____

Signature: _____ Date _____/_____/_____
(Parent/Guardian's signature if athlete is under 18)

SMCCCD Sports Medicine Medical Information Release Form

(* Athlete completes & signs form. Parent/Legal Guardian must sign as well if student is under 18 years of age)

Print Full Name: _____ G#_____ Sport:_____

I, (print name)_____, give permission to the San Mateo Community College District's Sports Medicine staff (including the athletic trainer, athletic training interns and team doctors), Sports Medicine staff at another school where I am competing, or emergency medical personnel (including paramedics, nurses, and doctors) to use the information from my (son's/daughter's) medical history, athletic screening exam, injury evaluations, rehabilitation reports and/or doctor's reports, in order to provide me with the best possible medical care should I become sick or injured while participating as an intercollegiate athlete.

Signature: _____ Date: _____
(Athlete)

Signature: _____ Date: _____
(Parent/Guardian's signature if athlete is under 18)

I give my consent to release information as may be requested from my (son's/daughter's) medical records, medical history, athletic screening exam, injury evaluations, rehabilitation reports and/or doctor's reports, in regards to any injuries or illnesses suffered during my participation as an athlete to the following individuals as indicated by the checked box and my ***initials*** in each category below:

Category 1: **To (Sports Medicine Staff) Athletic Trainers or Athletic Training Interns:**
for the purpose of providing appropriate medical treatment to me for my injuries/illnesses and/or to let those who are concerned about me know how I am doing.

☐ Yes ☐ No _____ ***Initial***

Category 2: **To the Press or Media:**
for the purpose of using the information to let others in the sports world and in the community, who are concerned about me, know how I am doing and/or to educate the public about my condition.

☐ Yes ☐ No _____ ***Initial***

Category 3: **To SMCCCD Administrators:**
for the purpose of using the information in dealing with issues regarding school insurance, billing, or litigation, and/or to let those who are concerned about me know how I am doing.

☐ Yes ☐ No _____ ***Initial***

Category 4: **To College Instructors or Coaches:**
for the purpose of using the information to update them in regard to my status as a student/athlete, as related to my ability to attend academic classes or to finish the semester, and/or my ability to safely participate in athletic practices or competition without further harm to my medical condition or injury and/or to let those who are concerned about me know how I am doing.

☐ Yes ☐ No _____ ***Initial***

Category 5: **To My Teammates on the Sport Team indicated at the top of this form:**
for the purpose of using the information to let those who are concerned about me know how I am doing.

☐ Yes ☐ No _____ ***Initial***

The San Mateo Community College District (SMCCD) maintains physical and procedural safeguards that comply with federal standards to protect your personal information. SMCCD does not use or disclose your information for any fundraising, marketing nor research activities. The information provided will only be used to help provide for prompt medical attention for the above named athlete.

I understand that a record will be kept of all individuals requesting such information and the date of the request. I also understand that this information may be used for only those purposes specifically indicated above. This information is confidential and will not be released except as provided in this Release Form. This Release Form remains valid until revoked by me in writing.

I hereby certify that all the information given on these forms is truthful and accurate. I understand that if this information is found to be untruthful and inaccurate, the SMCCD cannot be held liable for any consequences resulting from medical care given to me (my son/daughter) as a result of inaccurate information.

Signature: _____ Date: _____
(Athlete)

Signature: _____ Date: _____
(Parent/Guardian's signature if athlete is under 18)

SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

VOLUNTARY ACTIVITIES PARTICIPATION FORM
ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

I, _____, wish to participate in the following activity: _____

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness/death to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses/death which may result from participating in these activities include, but are not limited to, the following:

1. Sprains/strains
2. Fractured bones
3. Head/Concussion
4. Spine injuries
5. Paralysis
6. Loss of eyesight
7. Communicable diseases
8. Death

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the District.

I understand and acknowledge that in order to participate in these activities, I agree to assume liability and responsibility for any and all potential risks which may be associated with participation in such activities.

I understand, acknowledge, and agree that the District, its employees, officers, agents, or volunteers shall not be liable for any injury/illness/death suffered by me which is incident to and/or associated with preparing for and/or participating in this activity.

I acknowledge that I have carefully read this **VOLUNTARY ACTIVITIES PARTICIPATION FORM** and that I understand and agree to its terms.

_____

Participant's Signature Date

Participant's Printed Name: _____

_____

Parent/Guardian (if participant under 18 years of age) Date

This signed **VOLUNTARY ACTIVITIES PARTICIPATION FORM** must be on file with the College/District before a student will be allowed to participate in the above extra-curricular/co-curricular activity.