SMCCCD Pre-Participation Sports Screening

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

Print Last Name: ___________________________ 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 Do you have a heart implant or monitor? If yes describe ____

☐ Yes ☐ No Has anyone in your family had a heart problem/condition and/or surgeries such as but not limited to: Check condition if known.

☐Coronary artery disease ☐Heart attack ☐Heart Murmur ☐Balloon Angioplasty ☐Near Fainting/Fainting/Passing out

☐Skipped Heart Beats ☐Chest Pain ☐Bypass surgery ☐High Blood Pressure ☐Shortness of breath/excessive/unexplained

☐Extra Heart Beats ☐ Heart defect ☐Heart Palpitations ☐Marfan's syndrome ☐Irregular Heart Rhythm/Arrhythmia

☐Dilated Cardiomyopathy ☐Angina ☐Hypertrophic Cardiomyopathy ☐Excessive fatigue associated with exercise

☐Diabetes ☐Other __________________________________ ☐Other _________________________________

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

☐ Yes ☐ No Has it been more than two years since you had a physical exam that included blood pressure and a doctor listening to your heart?

☐ Yes ☐ No Have you ever had a medical illness/injury/surgery that kept you from participating in practice or competition? If "yes" explain below:

Injury/Illness/Surgery was_____________________ Year_______ Amount of time missed: Days_____ Weeks_____ Months______

☐ Yes ☐ No Are you allergic to: ☐Foods ☐Stinging Insects ☐Environmental agents/Pollen ☐Medications: List___________________________

☐ Yes ☐ No Do you use or have you ever used recreational drugs? ☐Never ☐Daily ☐Once/week ☐More than once/week ☐Once/month

☐ Yes ☐ No Do you use or have you ever used alcoholic drinks? ☐Never ☐Daily ☐Once/week ☐More than once/week ☐Once/month

☐ Yes ☐ No Do you ☐smoke cigarettes, ☐use dip/chew tobacco? ☐Never ☐Daily ☐Once/week ☐More than once/week ☐Once/month

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

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

☐ Yes ☐ No Do you get more easily tired or fatigued than your teammates during or after exercise? ☐Illness ☐Conditioning ☐Heat related

☐ Yes ☐ No Have you ever had chest discomfort, pain or pressure during exercise? ☐Mild Exercise ☐Moderate Exercise ☐Strenuous Exercise

☐ Yes ☐ No Has a doctor ever ordered or have you had a test for your heart? ☐EKG ☐Stress EKG ☐Halter Monitor ☐Echocardiogram ☐Stress Echo

☐ Yes ☐ No Have you ever been hospitalized, had surgery recommended or had surgery for a medical condition? Why and when? _____________________

☐ Yes ☐ No Were you born without or are you missing any of the following? ☐Kidney ☐Eye ☐Testicle ☐other organ:___________________

Yes	No	**Medication/Supplement Use**	Name of Medication	Reason /Condition	Name of Medication	Reason/Condition
		Over the counter medications				
		Prescription medication/pills				
		Inhalers				
		Supplements (ie Creatine)				
		Weight loss medications				
		Laxatives/Diet pills				
		Anabolic steroids/HGH				
		Birth control pills				
		Topical ointments/creams				

Yes	No	**Women Only**	Date
		Are you pregnant?	How many months?________
		Date of first menstrual cycle	Month_______ Year_______
		Longest time between periods	Days_______ Months ______
		No periods since	Month_______ Year_______

Yes	No	**Immunizations** (if known)	Year
		Tetanus	
		Hepatitis A	
		Hepatitis B	
		Hepatitis C	

Print Last Name: ___________________________ First Name_____________________ G#____________________ Sport:______________

2. ATHLETE'S MEDICAL HISTORY (con't): Have you ever had any of the following symptoms or medical conditions?

Yes	No	Year	Condition	Yes	No	Year	Condition	Yes	No	Year	Condition
			Chest Pain				Chest Tightness				Bronchitis /Chronic Bronchitis
			Dizzyness				Chest Pressure				Dilated Cardiomyopathy
			IHSS				High Cholesterol				Hypertrophic Cardiomyopathy
			Rheumatic Fever				Heart Murmur				Shortness of Breath
			Heart Infection				Irregular Heart Beats				Long QT Syndrome
			Asthma/EIA				Heart Skips Beats				Marfan's Syndrome
			Wheezing				High Blood Pressure				Fainting☐ Nearly Fainting☐
			Pneumonia				Pneumothorax				Sickle Cell Disease☐ Trait☐
			Ulcers				Cancer				Severe Dehydration
			Heat Cramps/Illness				Heat Stroke				Diabetes: ☐Type 1 ☐Type 2
			Anemia				Abdominal Pain				Blood Sugar: ☐High ☐Low
			Headaches				Migraine headaches				Concussion/Knocked Out
			Seizures				Skull Fracture				Hepatitis: ☐A ☐B ☐C
			Mononucleosis				Anorexia/Bulimia				HIV☐ Aids☐
			Hernia				Kidney Disease				Menstrual Irregularity/Cramps
			Appendectomy				Pregnancy				Bladder/Bowel Problems
			Impetigo				Folliculitis				Tinea Corporis (ringworm)
			Herpes Zoster				Tinea Cruris (jock itch)				Herpes Simplex (cold sore)
			Hearing Impairment				Vision Impairment				MRSA
			Thyroid Disease				Jaundice				Crohn's Disease
							Hemophilia				

3. Musculoskeletal History: Have you ever had any of the following injuries, surgery, tests or used orthopedic supports for injuries?

Yes	No	Year	Injury	Explain	Yes	No	Year	Injury	Explain
			Muscle Strain/Pull					☐Knee Pain/Injury ☐Surgery	
			Ligament Sprain					Painful Kneecap	
			Deep Bruise/Contusion					Knee gives way or buckles	
			Joint Locking or Catching					☐Hip Injury ☐Surgery	
			Torn ☐Cartilage ☐Labrum					☐Shoulder Injury ☐Surgery	
			Tendonitis/Tendinopathy					☐Elbow Injury ☐Surgery	
			☐ Fracture ☐ Stress Fracture					☐Wrist Injury ☐Hand Injury	
			☐ Nerve Injury ☐ Stinger					☐Finger ☐Thumb Injury	
			☐MRI ☐CT Scan for:					Other Orthopedic Surgery for:	
			☐Bone Scan ☐EMG for:					Neck Pain/Injury	
			☐Crutches ☐Sling for:					Arm/Finger Numbness	
			☐Splint ☐Cast for:					Arm/Hand Weakness	
			☐Foot Injury ☐Toe Injury					Upper Back Injury	
			☐Ankle Injury ☐Achilles Injury					Low Back Pain/Injury	
			Shin Splints/MTSS					Leg/Foot Numbness	
			Inability to participate from injury					Leg/Foot Weakness	
			Rib/Chest Injury					Hemo/Pneumothorax	
			Skull Fracture/Injury						

I certify that all the information on all the pre-participation sports screening exams forms, I have filled out, including my family medical history, my medical and musculoskeletal history are complete and accurate to the best of my knowledge:

Athlete's Signature____ Date:____/_____/_____

Parent's signature (if athlete is a minor under 18 y/o): ____ 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: ( ) -

Π M.D. Office Stamp Required

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)

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)

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)

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.