SUNY Canton Athletic Questionnaire and Pre-Participation Physical Exam

Return Completed Form to the Davis Health Center by mail, fax or email

Davis Health Center, Miller Campus Center 004, 34 Cornell Drive, Canton NY, 13617
P: 315-386-7333 F: 315-386-7932 E: healthcenter@canton.edu

DUE DATES: Fall Semester AUGUST 1ST Spring Semester JANUARY 1ST

All intercollegiate athletes are required to complete this form and submit it to the Davis Health Center NO SOONER than six months prior to the first day of tryouts/practice. You cannot be cleared for an intercollegiate team sport without completing this form. Additionally, the information contained in this form will only be used by the staff within the Davis Health Center and the college's Certified Athletic Trainer(s) for purposes of determining whether you pose a health threat/risk to yourself on the athletic field. This information will be discussed with you in detail before your first day of practice. This information will remain CONFIDENTIAL at all times.

THIS FORM IS FOR STUDENT ATHLETES ONLY

DO NOT USE THIS FORM IF YOU ARE NOT PARTICIPATING IN SUNY CANTON ATHLETICS

Students not participating in Athletics need to complete the Student Health History, Immunization and Physical Exam Form found on the Health Center's web page.

ALL FIELDS ON THIS FORM WITH AN ASTERISK (*) ARE REQUIRED AND NEED TO BE COMPLETED ENTIRELY.

*Student Information

*Print Name (First, Middle Initial, Last):*_____ *Student ID #:*_____

Preferred Name: _____ *Preferred Pronouns:* _____

*Date of Birth:*_____ *Phone Number (Home):(____)*_____ *Cell:(____)*_____

*Home Address:*_____
Street City State Zip

*Email Address:*_____
SUNY Canton email Personal Email

Entering Term: ☐ Fall ☐ Spring*Year:*_____*Program/Major Entering:*_____

*Emergency Contact Information

*Print Name (First, Last):*_____ *Relationship:*_____

*Home Phone:(____)*_____*Cell Phone:(____)*_____*Work Phone:(____)*_____

Current Health Care Provider Information

*Name & Title of Provider:*_____*Phone:(____)*_____

*Address:*_____
Clinic/Facility

_____
Street, City, State, Zip

Please continue this form and complete Parts I – III

Davis Health Center Office Use Only:

*Scanned by:*_____ *Reviewed by:*_____ *Received Date:*_____

*Immunizations Input into EHR by:*_____ *Health Hx Input into EHR by:*_____

Student Name: _____ DOB: _____

PART I - IMMUNIZATION/MENINGITIS REQUIREMENTS:

NYS PHL Section 2165 *requires students attending post-secondary institutions who were born on or after January 1, 1957 and registered for 6 or more credit hours to demonstrate proof of immunity against measles, mumps, and rubella.*

A COPY OF AN OFFICIAL IMMUNIZATION RECORD (I.E. HIGH SCHOOL RECORD) CAN BE ATTACHED.

● ***Required for ALL students:***

● **MMR** (2 doses, First one no more than 4 days before first birthday and at least 28 days apart)
1st____/____/____ (Mo Day Yr) 2nd____/____/____ (Mo Day Yr)

OR:

○ **MEASLES** 1st____/____/____ (Mo Day Yr) 2nd____/____/____ (Mo Day Yr)

○ **RUBELLA** ___/___/___ (Mo Day Yr) **MUMPS**____/____/____ (Mo Day Yr)

● **MENINGITIS** ***within the past 5 years*** **(**Circle one):
Menomune, Menactra, or Menveo Date: _____

OR:

○ ***Completed Meningitis Response Form*** *(see below)*

✸ ***Required for:***
Physical Therapy Assistant, Early Childhood, Health & Fitness Promotion, and Nursing students only

◆ ***Recommended for ALL students:***

✸ ◆ **TETANUS/DIPHTHERIA/PERTUSSIS** (circle one):
Tdap, Boostrix, Adacel or Td (if past hx of Tdap after age 11) (in last ten years): ____/____/___ (Mo Day Yr)

✸ ◆ **COVID-19** (circle one)**:**
Pfizer, Moderna, or Johnson & Johnson's

1st____/____/____ (Mo Day Yr) 2nd ____/____/___ (Mo Day Yr)
Booster ____/____/____

✸ ◆ **HEPATITIS B:**
1st____/____/____ (Mo Day Yr) 2nd ____/____/___ (Mo Day Yr)
3rd ____/____/___ (Mo Day Yr)
A titer proving immunity for each of the above is an acceptable alternative to receiving the immunizations. A copy of the titer results is required. Please attach documentation to this form.

✸ ◆ **VARICELLA (Chicken Pox):**
1st____/____/____ (Mo Day Yr) 2nd ____/____/___ (Mo Day Yr)
A titer proving immunity for each of the above is an acceptable alternative to receiving the immunizations. A copy of the titer results is required. Please attach documentation to this form.

✸ **Tb/PPD Mantoux:**
Required for all students at high risk for TB. *A second PPD Mantoux is required for health-related curriculums*.

❖ **#1 PPD MANTOUX**
Date Administered: _____
Date Read: _____
Result: _____ mm ☐ Negative ☐ Positive
☐ PPD was positive, a chest x-ray is required. Attach report

❖ **#2 PPD MANTOUX:**
(2nd PPD must be at least one week after the 1st PPD)
Date Administered: _____
Date Read: _____
Result: _____ mm ☐ Negative ☐ Positive
☐ PPD was positive, a chest x-ray is required. Attach report

***HEALTH CARE PROVIDER SIGNATURE REQUIRED:** **(LPN, RN, NP, PA, MD/DO) DATE:**_____

Name & Title:_____ **Signature:** _____

Address:_____ **Phone:**_____

*REQUIRED Meningitis Response Form:

NYS PHL Section 2167 *requires that all students attending college six (6) credit hours or the equivalent per semester complete a Meningitis Response Form.* More information can be found on the attached material of this document.

CHECK ONE BOX BELOW, SIGN AND DATE

I have (or for students under the age of 18: My child has):

☐ **had** meningococcal immunization within the past 5 years. **The vaccine record is attached or has been verified above.**

☐ **decided that I (or my child) will NOT obtain immunization against meningococcal meningitis disease at this time.** I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I understand that this decision can be changed at any time, and the vaccine may be available at my health care provider or local health department.

***Student's Signature**:_____ **Date:**_____

Student Name: _____ DOB: _____

Parent/Guardian signature if student is under the age of 18

PART II – ATHLETIC QUESTIONNAIRE *(completed by student athlete)*:

Student Name (First and Last): _____ **Date:** _____/_____/_____

Canton ID#: _____ **Sport:** _____ **DOB:** _____/_____/_____

Medications & Supplements: _____ [ ] NONE

Medication Allergies: _____ [ ] NONE

Other Allergies (environmental, food, etc.): _____ [ ] NONE

ALL ATHLETES MUST ANSWER THE FOLLOWING QUESTIONS:

Have you ever had or currently have any of the following:	***Circle One***		**WHAT & WHEN?**
Been denied participation in athletics due to medical reasons?	Yes	No	
Prior limits placed on participation in competitive sports by a medical provider?	Yes	No	
An injury/medical illness since your last physical requiring medical care?	Yes	No	
Surgeries, severe injuries, and/or hospitalizations overnight?	Yes	No	
Missing organs (eye, lung, kidney, testicle or ovary, etc.)?	Yes	No	
Heat exhaustion, heat stroke, and/or other conditions with heat?	Yes	No	
Mononucleosis (Mono) and/or Kawasaki's disease?	Yes	No	
Anemia, sickle cell (trait or disease), and/or a bleeding disorder?	Yes	No	
Problems with your blood pressure?	Yes	No	
Dizziness and/or fainting during and/or after exercise?	Yes	No	
Difficulty breathing, chest pain/tightness, and/or pressure during exercise?	Yes	No	
Heart murmur, palpitations, and/or irregular heartbeat?	Yes	No	
Myocarditis (infection of the heart muscle)?	Yes	No	
Tests ordered by a healthcare provider on your heart (EKG, echocardiogram, etc.)?	Yes	No	
Headaches severe enough to interfere with athletics?	Yes	No	
Seizures, concussion, and/or a head injury requiring medical evaluation?	Yes	No	
A broken bone, dislocated joint, and/or stress fracture?	Yes	No	
Spine, neck, and/or related injury?	Yes	No	
Lower back pain that prevented athletic participation?	Yes	No	
Any previous injuries which cause you complications now?	Yes	No	
Treatment for an eating disorder?	Yes	No	
Any tobacco use?	Yes	No	
Any related conditions with alcohol/substance abuse?	Yes	No	
Any mental health disorders, anxiety and/or depression?	Yes	No	
Any ongoing medical condition(s) (diabetes, asthma, seizures, etc.)?	Yes	No	
Any use of special braces and/or other protective equipment while participating in sports?	Yes	No	
Need for corrective lenses with sports participation?	Yes	No	
Any eye conditions (not vision correction) requiring treatment by an ophthalmologist?	Yes	No	
Other health-related condition/concern that is not listed?	Yes	No	

Family History:

Has any relative died before the age of 50 of causes other than an accident?	Yes	No	
Has any relative died before the age of 50 from a heart condition?	Yes	No	
Does any relative have hypertrophic cardiomyopathy, Marfan Syndrome, long or short QT syndrome, and/or other heart related conditions?	Yes	No	
Does any relative have diabetes, tuberculosis, mental illness, or other familial disease?	Yes	No	

FEMALE ATHLETES ONLY:

Are you currently having at least 9 menses (periods) per year?	Yes	No	

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

***Student Signature**: _____ **Date**: _____

Student Name: _____ DOB: _____

PART III – ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM *(completed by provider)*:

Student Name (First and Last): _____ **DOB:** ____/____/____

Height: _____ **Weight:** _____ **HR:** _____ **BP:** _____/_____ **Vision:** R 20/____ L 20/____
[] Contacts [] Glasses

	NORMAL	ABNORMAL/COMMENTS
APPEARANCE:		
SKIN	[]	_____
EENT	[]	_____
LYMPH	[]	_____
LUNGS	[]	_____
ABDOMEN	[]	_____
GENITALIA (males only)	[]	_____
Marfan Screen	[]	_____

(Marfan Stigmata: kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

CARDIOVASCULAR:		
FEMORAL PULSES	[]	_____
HEART SOUNDS	[]	_____
MUSCULOSKELETAL:		
NECK	[]	_____
BACK (no scoliosis)	[]	_____
SHOULDER	[]	_____
ELBOW/FOREARM	[]	_____
WRIST/HAND/FINGERS	[]	_____
DUCK WALK	[]	_____
SINGLE LEG HOP	[]	_____
(If any musculoskeletal areas are abnormal, a hip, knee & ankle exam is mandatory)		
HIP/THIGH	[]	_____
KNEE	[]	_____
ANKLE/FOOT	[]	_____

I have reviewed the athletic pre-participation questionnaire and completed the above physical and recommend the following:

[] CLEARED for all sports without restriction.

[] CLEARED for all sports without restriction,
WITH recommendations for further evaluation or treatment for: _____

[] NOT CLEARED for (sport): _____
REASON: _____

I have examined the above-named students and completed the preparticipation evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above

***HEALTH CARE PROVIDER SIGNATURE REQUIRED:** **(NP, PA, MD/DO)**

Name & Title (print): _____ **Date of Exam:** _____

Signature: _____ **Phone:** _____

Address: _____

Additional Information Regarding your Health Requirements

New York State Mandatory Immunization Requirements

MMR (Measles, Mumps, and Rubella):

New York State PHL Section 2165 requires students attending post-secondary institutions who were born on or after January 1, 1957 and registered for 6 or more credit hours to demonstrate proof of immunity against measles, mumps, and rubella.

Proof of immunity for MMR consists of:

- **Measles** – Must document two doses of live measles vaccine, *OR* a measles (rubeola) titer showing immunity.
- **Mumps -** Must document one dose of live mumps vaccine, *OR* a mumps titer showing immunity.
- **Rubella -** Must document one dose of live rubella vaccine, *OR* a rubella titer showing immunity.

Meningitis:

New York State PHL Section 2167 requires post-secondary institutions to distribute information about meningococcal disease and immunization to the students (or parents or guardians of students under the age of 18) accompanied by a response form. Acceptable documentation includes any of the following:

- A vaccine record indicating at least 1 dose of meningococcal ACWY vaccine within the last 5 years; *or*
- A signed Meningitis Response Form indicating that the student will not obtain immunization against meningococcal disease.

If the student has not received meningococcal vaccine within the past 5 years, then he/she **must submit the signed response form.*

Required Immunizations by Curriculum

Tuberculin Skin Test

This is not a vaccine, but a test to determine previous exposure to tuberculosis. This test is required for high risk students as defined by the Centers for Disease Control and Prevention. For more information, please refer to the CDC Web site at www.cdc.gov. ***Two doses of PPD Mantoux testing given at least one week apart is REQUIRED for the following curriculums: Nursing, Physical Therapist Assistant (PTA), and Health and Fitness Promotion (HEFI). Only one PPD test is REQUIRED for Early Childhood.***

Varicella Vaccine (chickenpox)

Must document two doses of varicella vaccine *OR* a varicella titer showing proof of immunity. Stated history or even documentation by a medical provider of a history of varicella will not be acceptable proof of immunity. ***Note: Varicella is REQUIRED for Nursing, PTA, HEFI, and Early Childhood students.***

Tetanus, Diphtheria, and Pertussis

After primary series of tetanus, diphtheria and pertussis, one dose of Tetanus toxoid, reduced diphtheria, and acellur pertussis (Tdap) vaccine is recommended after age 11 and a subsequent Td booster every 10 years. ***Note: Nursing, PTA, HEFI, and Early Childhood students are REQUIRED to have proof of Tdap vaccine after age 11 and a subsequent Td booster every 10 years.***

COVID-19

SUNY policy adopts the State of New York directive that public colleges and universities recommend that all students who intend to engage in-person at a SUNY campus or facility receive a COVID-19 vaccination. People are not considered fully vaccinated until 2 weeks after their second dose of the Pfizer-BioNTech or Moderna COVID-19 vaccine, or 2 weeks after a single-dose of Johnson & Johnson's Janssen COVID-19 vaccine. ***REQUIRED for Nursing, PTA, HEFI, and Early Childhood students.***

Recommended Immunizations

Hepatitis B

Series of three doses given prior to college entry is strongly suggested for *all* college students. ***It is REQUIRED that Nursing, PTA, HEFI, and Early Childhood students show proof of Hep B vaccines or sign a declination/waiver form.***

Physical Examination Requirements

1. **International Students**
2. **Nursing, Physical Therapy Assistant, Health & Fitness Promotion, and Early Childhood students.** Students will **not** be allowed to participate in their clinical or fieldwork practice unless this health form/physical examination is on file.
3. **Intercollegiate Athletes: DO NOT USE THIS FORM**. Athletes need to complete the ***Athletic Pre-Participation Physical Exam Form*** which is available on the Athletic and Health Center web pages. Be advised that athletes will **not** be allowed to try out for a team or to practice with a team until a pre-admission physical examination is completed.

***For all other students the physical exam is recommended but not required.**

Meningitis Information Sheet

The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series.

What is meningococcal disease?

Meningococcal disease is caused by bacteria called *Neisseria meningitidis*. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications including death. Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Infants younger than one year of age and teenagers or young adults
- Living in crowded settings like college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen
- Being treated with Soliris® or who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak

What are the symptoms?

Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:

- Weakness and feeling very ill, sudden high fever, Eyes sensitive to light
- Headache and Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash

How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

Is there treatment? Early diagnosis of meningococcal disease is very important.

If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

What are the complications?

Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include hearing loss, brain damage, kidney damage and limb amputations.

What should I do if I or someone I love is exposed?

If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

What is the best way to prevent meningococcal disease?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age and the second dose (booster) at age 16. It is very important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease. Talk to your health care provider today if your teen has not received two doses of vaccine against meningococcal A, C, W and Y.
- Teens and young adults can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend vaccine against the "B" strain.
- Others who should receive the vaccine include: Infants, children and adults with certain medical conditions; People exposed during an outbreak; Travelers to the "meningitis belt" of Sub-Saharan Africa, and Military recruits.

Additional Information

- Travel and meningococcal disease http://wwwnc.cdc.gov/travel/diseases/meningococcal-disease
- Learn more about meningococcal disease (cdc.gov) http://www.cdc.gov/meningococcal/
- More information about vaccine-preventable diseases http://www.health.ny.gov/prevention/immunization/