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:

*Received by/Date:*_____ *Reviewed by:*_____ *Scanned 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____/____/____ 2nd____/____/____
Mo Day Yr Mo Day Yr

OR:

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

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

● **MENINGITIS** ***within5 years of admission***):
Men ACWY ____/____/___
Mo Day Yr

OR:

○ **2 Doses of MENINGITIS B** ***within 5 years of admission***
1st____/____/____ 2nd____/____/____
Mo Day Yr Mo Day Yr

OR:

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

✸ ***Required for certain curriculums. Please see page 5 for more information.***

◆***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

✸ ◆ **HEPATITIS B:**
1st____/____/____ 2nd ____/____/____
Mo Day Yr 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____/____/____ 2nd ____/____/____
Mo Day Yr 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.

◆ **COVID-19:** Most recent: ____/____/___
Mo Day Yr

◆ **Gardasil (HPV4, HPV9):**
1st____/____/____ 2nd____/____/___ 3rd ___/___/___
Mo Day Yr Mo Day Yr Mo Day Yr

✸ **TUBERCULOSIS SCREENING:**
Required for all students at high risk for TB. *A second PPD Mantoux is required for certain 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

OR:

✸ **QUANTIFERON GOLD- TB BLOOD TEST:**
Test Date: _____ Result Date: _____
Test Result: _____

***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 5 years of admission. **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:**_____

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

Student Name: _____ DOB:_____

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

Student Name (First and Last): _____ **Date:** _____/_____/_____
Canton ID#: _____ **Sport(s):**_____ **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 restrictions.

[] CLEARED for all sports without restrictions WITH recommendations for further evaluation or treatment for:

_____

[] CLEARED for all sports WITH the following restrictions:_____

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

I have examined the above-named student and have completed the preparticipation evaluation.

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

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

Signature: _____ **Phone:**_____

Address:_____

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 **OR** 2 doses of Meningococcal B vaccine within 5 years of admission without any breaks in enrollment;

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 5 years of admission date, then they **must submit the signed response form.*

Recommended Immunizations

Tuberculin Skin Test

Tuberculin skin test **OR** Quantiferon Gold-TB blood test. This is 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. * ***REQUIRED for the following curriculums: Nursing, Physical Therapist Assistant (PTA), and 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.

****REQUIRED for the following curriculums: Nursing and PTA***

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.

****REQUIRED for the following curriculums: Nursing and PTA***

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.

****While this is not a requirement, it is HIGHLY recommended for the following curriculums: Nursing and PTA***

Hepatitis B

Series of three doses given prior to college entry is strongly suggested for *all* college students. **** REQUIRED for the following curriculums: Nursing, PTA students must show proof of Hep B vaccines OR sign a declination/waiver form.***

Gardasil (HPV4, HPV9)

HPV vaccines are vaccines that protect against either two, four, or nine types of human papillomavirus, which have been implicated in causing certain infections and cancers.

Physical Examination Requirements

1. **International Students**
2. **Nursing and Physical Therapy Assistant students.** Students will **NOT** be allowed to participate in their clinical or fieldwork practice unless a physical examination is completed and on file. The physical examination must be within the last year.
3. **Intercollegiate Athletes:** 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 and on file. The physical examination must be within the last 6 months.

***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/