Napa Valley College
Student Health Service
Sports Physical Exam

History and Review of Systems (pg 1)

Directions: Fill out this page and the next one, then stop. If you are a special needs athlete, also fill out the third page…..

Name:_________________________ Birthdate:________ Age ________ Sex:______

Sport(s) you wish to play:_________________________

****

Medications/Allergies: List all medications you regularly take, including prescription meds, over the counter meds, and supplements such as vitamins:

____

____

____

Are you allergic to any medications: Yes___ No ___ List:_________________________

Do you have other allergies (pollen, bee stings, etc): Yes____ No: _____
List: ____________________

Do you have any dietary restrictions: Yes___ No:___ List:_________________________

Do you have any current health problems?
___ Asthma ____ Diabetes ___ Anemia ___ Infection ___ Rash ____Fever ____ Cough ___ recent mono
___ Sores or wounds Other_________________________

Health Habits

Do you get regular exercise: Yes___ No___ What type?______________ hours per week _________
Do you smoke?: Yes___ No___ If yes, how many packs per day?______________

Family History

Have any relatives died before the age of 50 from heart problems? Yes___ No____

____

Do you have relatives with heart rhythm problems? Yes___ No___

____

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History and Review of Systems (pg 2)

Name:_________________________________ Birthdate:_________

Personal Health History

Make a check in YES column if you have had:	YES	Description
Hospitalization		
Surgery		
Sidelined from a sport due to injury or illness		
Unusual fatigue, tiredness or lack of endurance		
Born without, or had removed, a kidney, testicle, spleen or any other organ		
Vision problems/use of glasses or contacts		
Hearing problems/wear hearing aid		
Bleeding problems		
Sickle cell trait or disease		
Heat exhaustion, or other symptoms with heat or cold		
Chest pain or discomfort during exercise		
Heart racing or skipping beats		
High blood pressure		
Heart murmur		
Heart problems or heart disease		
Asthma		
Used an inhaler		
Unusual shortness of breath, wheezing, or coughing with exercise		
Other lung problems		
Head injury or concussion		
Loss of consciousness, fainting or near-fainting		
Seizures or epilepsy		
Dizziness		
Mental health issues		
Eating disorder		
Injury to bone, muscle, ligaments or tendons such as sprains, tears, fractures		
Back or spine problems		
Joint pain or swelling		
Hernia, bulge, or pain in groin area		
Regular use of brace, orthotics or other assistive device		
Need for brace, orthotics or assistive device for sports		
Females: is there a chance you are pregnant?		

Is there anything else we should know about your health? ____

____

Do you have any concerns you wish to discuss today? ____

____

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

Signature of athlete:____________________ Signature of parent or guardian_______________ Date______

******************STOP HERE ********************

Napa Valley College
Student Health Service
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Supplemental History for Athletes with Special Needs

Name:______________________________ Birthdate:________ Date of Exam:________

Type of disability:____________________________

Date disability started:____________________________

Cause of disability (birth defect or genetic, disease, accident, other)____________________________

Make a check in YES column if you have had:	YES	Description
Does your disability limit your physical activities?		
Do you have muscle spasticity?		
Do you have weakness, numbness or tingling in arms or legs?		
Do you have problems with coordination?		
Have there been any recent changes in your coordination or ability to walk?		
Have you had autonomic dysreflexia?		
Od you have osteopenia or osteoporosis?		
Do you have difficulty with bowel or bladder control?		
Do you need special devices for bowel or bladder function?		
Do you have a learning disability which would affect your sports participation?		
Do you have a communication disability which would affect your sports participation?		
Do you have a mental health problem which would affect your sports participation?		
Do you have atlantoaxial instability?		

Is there anything else we should know about your disability or needs?____________________________

____

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

Signature of athlete:________________ Signature of parent or guardian______________ Date_____

Napa Valley College
Student Health Service
Sports Physical Exam

Physical Exam

Name:________________________________ Birthdate:________ Date of Exam:_________

Height____ Weight____ BMI____ BP _____ Pulse______ Temp____

Vision Rt 20/____ Lt 20/____ Corrected Y___ N___

	Normal	Abnormal findings
General Appearance*		
Neuro: general mental status		
Neuro: DTR's, tremor, general coordination		
HEENT		
Lungs (dyspnea, breath sounds)		
Heart (rhythm, murmurs)		
Pulses (simultaneous radial and femoral)		
Abdomen		
GU (males)		
Skin (rashes, sores)		
Musculoskeletal (ROM, strength, deformities)		
Neck		
Back		
Upper extremities (shoulders, arms, hands)		
Lower extremities (hips, legs, feet)		
Functional: Squat, toe-touch, single-leg hop		

- Marfan stigmanta (kyphoscoliosis, high arched palate, kpectus excavatum, arachnodactyly, arm span > height, joint hyperlaxity, myopia, aortic insufficiency, MVP)

Napa Valley College
Student Health Service
Sports Physical Exam

Clearance

Name:______________________________________ Birthdate:_________ Date of Exam:__________

__ Cleared for all sports without restriction

__ Cleared with restrictions:____

__ Not cleared pending further evaluation:____

__ Not cleared for sports participation____

Explanation/Recommendations

____

____

____

Emergency Information (Severe allergies, etc)

____

____

____

Examining clinician:

Name____________________________ Signature_______________________________ Date___________

Napa Valley College Student Health Service
2277 Napa-Vallejo Highway
Napa, CA 94558
(707) 256-7780

NAPA VALLEY COLLEGE
SPORTS MEDICINE INFO CARD

NAME____

SS#______________________________ AGE______ SEX________

ADDRESS____

____

PHONE (   ) _______________________________________

PARENT'S ADDRESS___________________________________

____

PHONE (   )_______________________________________

DO YOU HAVE HEALTH INSURANCE?___________________

NAME OF COMPANY__________________________________

POLICY#____

IN CASE OF EMERGENCY NOTIFY:______________________

____

PHONE (   )_______________ RELATION_______________

MEDICAL ALERT______________________________________

NAPA VALLEY COMMUNITY COLLEGE DISTRICT
ACKNOWLEDGMENT & ASSUMPTION OF POTENTIAL RISK

I wish to participate in the college sponsored activity(ies) of ________________________

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate. I understand and acknowledge that some of the injuries/illnesses which may result from participating in these activities include, but are not limited to the following:

1. Sprains/Strains
2. Fracture bones
3. Unconsciousness
4. Head and/or back injuries
5. Paralysis
6. Loss of eyesight
7. Communicable diseases/blood borne pathogens
8. Death

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 college, its employees, officers, agents, or volunteers shall not be liable for any injury/illness suffered by me which is incident to and/or associated with preparing for and/or participating in the activity(ies).

Unless otherwise advised, I understand that I am responsible for my own transportation to and from the activity(ies) and the college assumes no liability for loss or injury resulting from my transportation. Although the college may assist in coordinating the transportation any assistance and/or recommendations provided is not mandatory.

If the college is providing transportation but I do not use the transportation, I am responsible to make my own transportation arrangements and the college assumes no responsibility or liability of any kind.

I have no known medical condition which may pose a risk to the health and safety of me or others by participating in the activity(ies).

I acknowledge that I have carefully read this ACKNOWLEDGEMENT & ASSUMPTION OF POTENTIAL RISK form and that I understand and agree to its terms.

Student Signature: ________________________________ DATE: ______________

Print Name: ________________________________

Office of Athletic Training
Napa Valley College
2277 Napa-Vallejo Highway
Napa, CA 94558

CONSENT TO TREAT AND INFORMATION RELEASE AUTHORIZATION

I, ____, age ____________
while participating in the Intercollegiate Athletic program at Napa Valley College, hereby consent to be treated by the Student Health Service, Team Physician(s), Members of the Napa Valley College Athletic Training Staff or any other Medical Doctor or Medical Facility recommended by the Team Physician(s) or Certified Athletic Trainer(s).

I expressly authorize the Student Health Service or Napa Valley College, any Hospital, Medical Doctor, Medical Facility or Pharmacy, which has rendered me treatment or service to release/disclose medical information pertinent to a specified injury/illness to the Athletic Training Department of Napa Valley College or to their designated team physician in order to facilitate my proper care. I authorize the Athletic Training staff of Napa Valley College to use or disclose any information regarding my injury/illness to my coach(s) or to other medical providers in order to better facilitate my care.

A photo static copy of this authorization shall be considered as effective and valid as the original.

Date: ____________ Printed Name: ______________________________

Student Signature: ____________________________

Social Security Number: _______________________

Date of Birth: _______________________________

Parent/Guardian Name: ________________________

Home Address: ______________________________

City/State/Zip: _______________________________

Phone Number: ______________________________

Parent Guardian Signature: _____________________

Alternate Person and Phone Number (in case of emergency): _____________

____

(In order to meet HIPAA Law criteria this from will be good for one academic school year and will be signed on a yearly basis throughout the athlete's intercollegiate sport career.)

N.V.C. SPORTS MEDICINE

As a member of a Napa Valley College Intercollegiate Athletic Team, there are certain responsibilities which must be understood prior to participation in an intercollegiate contest. These items are as follows:

MEDICAL CARE:

1. I understand that it is my responsibility to have a physical examination prior to the beginning of practice or competition.

2. I understand that it is my responsibility to report any athletic injury I incur to the Athletic Trainer within 24 hours of the occurrence of the injury.

3. I understand that the Napa Valley College Athletic Trainer is the individual responsible for certifying me eligible to return to practice and/or competition following an injury. I also understand that if the training room staff sends me to the hospital or a physician/nurse for further clearance, that I must return with **written** clearance and/or limitations. If there is no written documentation provided, I will not participate.

4. I understand that the STUDENT & INTERCOLLEGIATE ATHLETIC ACCIDENT INSURANCE is a secondary insurance.

5. I understand that the athletic training room equipment, ace wraps, braces, checked out to me become my personal responsibility, and I am to return all equipment in good condition when it is deemed no longer necessary as per the Athletic Training Staff.

I have read the above regulations and expectations. I understand that as an athlete, I am expected to abide by the Napa Valley College Intercollegiate Athletic Training rules, and regulations as a prerequisite to my athletic participation.

Name: ______________________________

Student Signature: ______________________

Sport: ______________________________

Date: __________

Napa Valley College

Student Athlete Concussion Acknowledgement Statement

I _______________________ understand that it is my responsibility to report all injuries and illnesses (including concussions) to my athletic trainer and/or physician.

I have read and understand the Concussion fact sheet and am aware of the following information:

1. A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.
2. A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.
3. You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
4. If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.
5. I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.
6. Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.
7. In rare cases, repeat concussions can cause permanent brain damage, and even death.

I acknowledge that I have read and understand the Head Injury Fact Sheet and accept these responsibilities to protect my well-being. If I have any questions, it is my responsibility to as the athletic training staff or my coach.

_______________________________   _______________

Signature of Student-Athlete   Date

____

Printed Name of Student-Athlete

CONCUSSION

A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- Can happen even if you do not lose consciousness.

HOW CAN I PREVENT A CONCUSSION?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

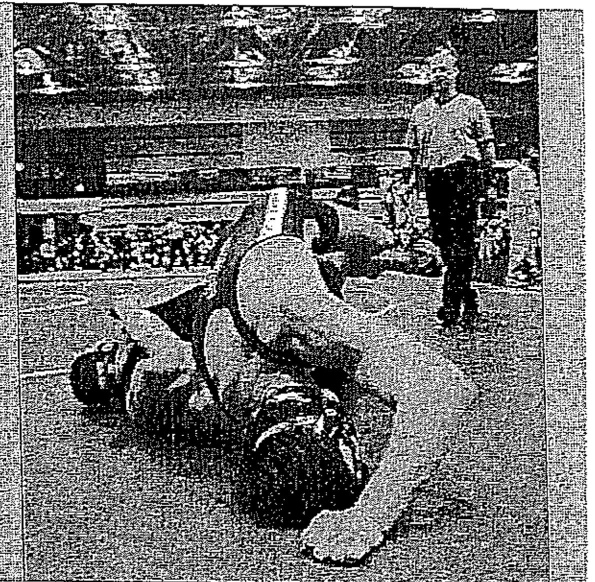
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.



IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.