**MGSA Dance Pre-Participation Assessment**

**First Name:**

**Last Name:**

**Rutgers Identification Number (RUID):**

In order to participate in collegiate dance classes, all incoming BFA students must complete the Pre-Participation Assessment. This includes the Preliminary form submission and Physical Exam. Students will NOT enter into any dance classes without completing the assessment.

**Preliminary form submission – due by June 1, 2021 (or within two weeks of enrolling at Mason Gross):**

This 5-page form has three distinct sections that should be completed and sent to the Rutgers University Health Center (contact information outlined in page 2). Please be sure to fax or email **all five pages** of this document.

1. Preferred Mode of Communication Form

2.The 2-page History From, should be completed with as much detail as possible. If further clarification is needed, you will receive an email from the Rutgers Student Health Sports Medicine Physician asking for further questions or informing you that further evaluation is needed by your home physician.

            a. For any **"Yes"**answer in the PPE History form, please provide the following information on page

                 i. When did this problem occur?

                 ii. What was the specific diagnosis?

                 iii. How was it treated?

                 iv. When was your last medical evaluation/treatment for this issue?

                 v. Are you currently undergoing any physical therapy or other treatments for this issue?

                  vi. Has this issue still be active or affecting you recently/currently?

3.  If you are under the age of 18 at the time the student is filling out the form, parent/guardians must fill out page 5: Permission to Diagnose and Treat Minors Form.

**Preferred Mode of Communication Consent Form**

Rutgers Student Health Services (RSH) is committed to ensuring the safety and security of Protected Health Information in all aspects of communication. Outlined below are the options to communicate with the professional health staff at Rutgers Student Health Services. Please review and select the mode of communication you would like to proceed with by completing this form.

1. EMAIL – Due to the nature of electronic mail, use of regular (Rutgers based or other commercial) e-mail cannot be guaranteed to be confidential. If you would like to communicate with Rutgers Student Health Services through e-mail\*, select this box.

2. FAX FORM AND EMAIL FOLLOW UP– All faxed forms should be sent directly to the Rutgers Student Health Services (information listed below). Upon receiving this form, Rutgers Student Health Services will communicate any follow-up information through e-mail\*, check this box.

3. FAX FORM AND PHONE FOLLOW UP- All faxed forms should be sent directly to the Rutgers Student Health Services (information listed below). Upon receiving this form, Rutgers Student Health Services will communicate any follow-up information through phone, check this box.

\*Carefully consider whether to use regular unsecure email for information that may be considered especially sensitive, such as abnormal laboratory tests, HIV, mental health, or substance use issues. Please note, all e-mails will become part of the student health record. While every attempt is made to promptly answer e-mail, this cannot be guaranteed. Regular e-mail may be appropriately used for appointment reminders, health education information, and immunization reminders/updates.

I If you have opted to communicate through e-mail, please email this completed form (5 pages) to Dr. Kenton at ak1462@echo.rutgers.edu. **ALL COMPLETED FORMS MUST BE IN PDF FORMAT ONLY**. **IF EMAILING NO PICTURES OR IMAGES WILL BE ACCEPTED.**

If you have opted to send your form via fax, please print and complete this form (5 pages) and fax it to:

Fax Number: 732-932-8255
Subject: MGSA 2021 Dance Pre-Participation Forms
Attention: Rose Bartley, Asst. Dir Health Information & Patient Service

**ACKNOWLEDGMENT:**

By signing this form, you acknowledge that you have read, understand, and accept the risks of the mode of communication selected above.

STUDENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE (if student is under 18):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY FORM**

*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)*

Date of Exam:

Name:

Date of birth:

Gender:       Age:

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Enter text here.

|  |  |  |
| --- | --- | --- |
| Do you have any allergies? | [ ] Yes [ ] No If yes, please identify specific allergy below. |  |
| [ ]  Medicines | [ ]  Pollens [ ]  Food [ ]  Latex | [ ]  Stinging Insects |

**Explain “Yes” answers on page #2. Circle questions you don’t know the answers to.**

|  |  |  |
| --- | --- | --- |
| MEDICAL QUESTIONS | Yes | No |
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? |  [ ]  |  [ ]  |
| 27. Have you ever used an inhaler or taken asthma medicine? |  [ ]  |  [ ]  |
| 28. Is there anyone in your family who has asthma? |  [ ]  |  [ ]  |
| 29. Were you born without or are you missing a kidney, an eye, a testicle(males), your spleen, or any other organ? |  [ ]  |  [ ]  |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? |  [ ]  |  [ ]  |
| 31. Have you had infectious mononucleosis (mono) within the last month? |  [ ]  |  [ ]  |
| 32. Do you have any rashes, pressure sores, or other skin problems? |  [ ]  |  [ ]  |
| 33. Have you had a herpes or MRSA skin infection? |  [ ]  |  [ ]  |
| 34. Have you ever had a head injury or concussion? |  [ ]  |  [ ]  |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? |  [ ]  |  [ ]  |
| 36. Do you have a history of seizure disorder? |  [ ]  |  [ ]  |
| 37. Do you have headaches with exercise? |  [ ]  |  [ ]  |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? |  [ ]  |  [ ]  |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? |  [ ]  |  [ ]  |
| 40. Have you ever become ill while exercising in the heat? |  [ ]  |  [ ]  |
| 41. Do you get frequent muscle cramps when exercising? |  [ ]  |  [ ]  |
| 42. Do you or someone in your family have sickle cell trait or disease? |  [ ]  |  [ ]  |
| 43. Have you had any problems with your eyes or vision? |  [ ]  |  [ ]  |
| 44. Have you had any eye injuries? |  [ ]  |  [ ]  |
| 45. Do you wear glasses or contact lenses? |  [ ]  |  [ ]  |
| 46. Do you wear protective eyewear, such as goggles or a face shield? |  [ ]  |  [ ]  |
| 47. Do you worry about your weight? |  [ ]  |  [ ]  |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? |  [ ]  |  [ ]  |
| 49. Are you on a special diet or do you avoid certain types of foods? |  [ ]  |  [ ]  |
| 50. Have you ever had or thought you might have an eating disorder? |  [ ]  |  [ ]  |
| 51. Do you have any concerns that you would like to discuss with a doctor? |  [ ]  |  [ ]  |
| FEMALES ONLY |  [ ]  |  [ ]  |
| 52. Have you ever had a menstrual period? |  [ ]  |  [ ]  |
| 53. How old were you when you had your first menstrual period? |  |
| 54. How many periods have you had in the last 12 months? |  |
| COVID-19 QUESTIONS |  |
| 55. Have you been or are you currently diagnosed with C |

|  |  |
| --- | --- |
|  [ ]  |  [ ]  |

 |
| 56. If yes, was it within the last 90 days? |

|  |  |
| --- | --- |
|  |  |

 |
| 57. What was the date of your positive test? Mm/dd/yyy |  |
| If you are diagnosed with COVID-19 after this form is submitted, YOU MUST INFORM DR. KENTON BEFORE THE FALL 2021 SEMESTERS STARTS.  |  |

|  |  |  |
| --- | --- | --- |
| GENERAL QUESTIONS | Yes | No |
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? |  [ ]  |  [ ]  |
| 2. Do you have any ongoing medical conditions? If so, please identify below: [ ]  Asthma [ ]  Anemia [ ]  Diabetes ☐ InfectionsOther:  |  [ ]  |  [ ]  |
| 3. Have you ever spent the night in the hospital? |  [ ]  |  [ ]  |
| 4. Have you ever had surgery? |  [ ]  |  [ ]  |
| HEART HEALTH QUESTIONS ABOUT YOU | Yes | No |
| 5. Have you ever passed out or nearly passed out DURING orAFTER exercise? |  [ ]  |  [ ]  |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? |  [ ]   |  [ ]  |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? |  [ ]  |  [ ]  |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:[ ]  High blood pressure [ ]  A heart murmur[ ]  High cholesterol [ ]  A heart infection[ ]  Kawasaki disease Other:  |  [ ]  |  [ ]  |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) |  [ ]  |  [ ]  |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? |  [ ]  |  [ ]  |
| 11. Have you ever had an unexplained seizure? |  [ ]  |  [ ]  |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? |  [ ]  |  [ ]  |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Yes | No |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? |  [ ]  |  [ ]  |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? |  [ ]  |  [ ]  |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? |  [ ]  |  [ ]  |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? |  [ ]  |  [ ]  |
| BONE AND JOINT QUESTIONS | Yes | No |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? |  [ ]  |  [ ]   |
| 18. Have you ever had any broken or fractured bones or dislocated joints? |  [ ]  |  [ ]  |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? |  [ ]  |  [ ]  |
| 20. Have you ever had a stress fracture? |  [ ]  |  [ ]  |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) |  [ ]  |  [ ]  |
| 22. Do you regularly use a brace, orthotics, or other assistive device? |  [ ]  |  [ ]  |
| 23. Do you have a bone, muscle, or joint injury that bothers you? |  [ ]  |  [ ]  |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? |  [ ]  |  [ ]  |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? |  [ ]  |  [ ]  |

58. When you are in a car (driving or riding as a passenger) what percentage of the time do you wear your seat belt?

**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/guardian Date

**COVID-19 QUESTIONS**

Have you been or are you currently diagnosed with Covid-19?

**FOR ANY “YES” QUESTIONS ANSWERED ON PAGE 1, PLEASE PROVIDE THE FOLLOWING INFORMATION**

1. When did this problem occur?
2. What was the specific diagnosis?
3. How was it treated?
4. When was your last medical evaluation/treatment for this issue?
5. Are you currently undergoing any physical therapy or other treatments for this issue?
6. Has this issue still been active or affecting you recently/currently?

This form is to be completed by the parent/guardian of any student who is not 18 by the date this form is submitted.

