Connecticut State University Student Health Services Form

Please note University Health Services will not accept copies of immunization forms. This Connecticut State University Student Health Services Form is mandatory and the only form that will be accepted as proof of vaccination. Dates of immunizations must be written in the appropriate fields. Please make this clear to your healthcare provider’s office when you drop off the form.

REQUIRED FOR ALL INCOMING FULL TIME STUDENTS
(Including transfer and exchange students, and those changing from part-time to full-time status)

All full time students are required to submit this form to University Health Service no later than July 15 for the fall semester and December 15 for the spring semester. Proof of adequate immunization against measles, mumps, rubella (MMR) and varicella (chicken pox) and completion of the Tuberculosis (TB) Risk Assessment are required. Failure to meet this requirement will affect your ability to register for classes or change your schedule.

Guidelines for these state immunization requirements are below. If your form is submitted with any missing information, we will notify you requesting the necessary data. Make sure your correct contact information is updated on your WebCentral/Student Pipeline account. Messages regarding your health information requirements can also be seen on your Registration Status in your WebCentral account.

PLEASE NOTE TRANSFER STUDENTS: Your health information is not automatically transferred with your academic records from your prior university. You must submit a completed form with all required information as if you were a first time college student. Transfer students, like other incoming full time students, are required to provide proof of adequate immunization against measles, mumps, rubella (MMR) and varicella (chicken pox) along with completion of the Tuberculosis (TB) Risk Assessment.

University Health Services is here to assist you in the successful completion of your academic journey. If you encounter any difficulty in getting the required information or you have any questions please call us at (860) 832-1925. We are here to do everything we can to make your transition to life at CCSU as easy as possible. Please look our webpage, www.ccsu.edu/health, for more information about the services we offer.

Congratulations on your admission to CCSU!

University Health Services
Christopher Diamond, MD, Director
Marisol Aponte, APRN, Associate Director

Revised 4/11/12
Immunization Requirements and Exemptions

Connecticut General Statutes and CCSU require the following for all matriculated students

- **Proof of immunity to Measles (Rubeola):** you must provide proof of one of the following:
  - Two measles or two MMR immunizations (one after your 1\(^{st}\) birthday and one at least one month later); OR
  - Lab results showing a positive measles titer (blood test)

- **Proof of immunity to Rubella:** you must provide proof of one of the following:
  - Two rubella or two MMR immunizations (one after your 1\(^{st}\) birthday and one at least one month later); OR
  - Lab results showing a positive rubella titer (blood test)

- **Proof of immunity to Mumps:** you must provide proof of one of the following:
  - Two mumps or two MMR immunizations (one after your 1\(^{st}\) birthday and one at least one month later); OR
  - Lab results showing a positive mumps titer (blood work)

- **Proof of immunity to Varicella (chicken pox):** you must provide proof of one of the following:
  - Two varicella immunizations; OR
  - Lab results showing a positive varicella titer (blood test),

*Certification of confirmed cases of measles, mumps, rubella & varicella by a licensed health care provider may be submitted in lieu of the above.*

- **Proof of Meningococcal vaccination (Menactra) is required for all residential students prior to room assignment. No student may move into campus housing without proof of this vaccine. It is strongly recommended that all students be vaccinated against this disease. If it has been 5 years since your immunization, speak to your medical provider about getting a booster shot.**

**Hepatitis B:** The American College Health Association, the Connecticut Public Health Department, and the Centers for Disease Control recommend students be immunized against Hepatitis B *(this is not required).*

**Tetanus:** A booster shot is recommended every ten years and is **required for all varsity athletes.**

**IMMUNIZATION EXEMPTIONS**

- Students born prior to January 1, 1957 are exempt by age from the measles, mumps, and rubella requirement.
- Students born prior to January 1, 1980 are exempt by age from the varicella requirement.
- Vaccination waivers for religious or medical reasons are acceptable and can be found at [www.ccsu.edu/health/forms](http://www.ccsu.edu/health/forms).
  
  Exemptions for either medical or religious reasons subjects the individual to exclusion from campus in the event of an outbreak of a disease for which immunizations are required.
- Online learners do not need to meet the immunization requirements.
Connecticut State University Student Health Services Form

State of Connecticut and Connecticut State Universities REQUIRE:

<table>
<thead>
<tr>
<th>Vaccine &amp; Date Given</th>
<th>OR Incidence of Disease</th>
<th>Titer Test Results</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Measles #1 OR MMR</td>
<td>Date:</td>
<td>Measles Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>2 Mumps #1 OR MMR</td>
<td>Date:</td>
<td>Mumps Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>3 Rubella #1 OR MMR</td>
<td>Date:</td>
<td>Rubella Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>4 Varicella #1 OR Disease Chicken Pox</td>
<td>Date:</td>
<td>Varicella Titer Date:</td>
<td>Must be at least 28 days after 1st immunization.</td>
</tr>
<tr>
<td>5 Meningococcal Vaccine Type or Brand: Date:</td>
<td></td>
<td></td>
<td>Must be at least 28 days after 1st immunization.</td>
</tr>
</tbody>
</table>

**TUBERCULOSIS (TB) RISK QUESTIONNAIRE - A through D To be answered by the Student**

A. Have you ever had a positive tuberculosis skin or blood test in the past?

B. Did you answer "Yes" to the question "Do you have a positive tuberculosis skin or blood test in the past?"?

C. Were you born in one of the countries listed below?

D. Have you traveled or lived for more than one month in one or more of the countries listed below?

6. *Required only if in university owned housing.*

Prior BCG does not exempt patient from this requirement.

6a. TB BLOOD TEST OR interferon-gamma release assay

6b. CHEST X-RAY

6c. TB TREATMENT MEDICATION (with dose):

Other Vaccination History

<table>
<thead>
<tr>
<th>Hepatitis B #1 Date</th>
<th>Hepatitis B #2 Date</th>
<th>Hepatitis B #3 Date</th>
<th>Hepatitis Titer Date Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>POS</td>
</tr>
</tbody>
</table>

Other Vaccination:

I confirm that the information above is accurate.

Clinician Signature: __________________________ Date: ____________

Physical Examination Affirmation: I have examined this patient on __________ and find no medical condition that would prohibit him/her from participating fully in all activities including physical education, trying out for competitive sports or military training and employment.

Clinician Signature: __________________________ Date: ____________

Consent for treatment required to be signed (if you are less than 18 years of age signatures of both the student and one parent/guardian are required)

Signature of Student: __________________________ Date: ____________

Signature of Parent/Guardian: __________________________ Date: ____________

Continue to Page 2 →
**PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS**  **BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED**

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Home/Personal Email Address</th>
<th>Student Cell Phone</th>
</tr>
</thead>
</table>

**Permanent Home Information**

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
<th>Notify in Case of Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Street Address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Telephone #:</th>
<th>FAX #:</th>
</tr>
</thead>
</table>

**Personal Physician/Healthcare Provider**

**Personal Medical History - Please circle all below that apply to you**

- [ ] Check here if none apply
  - Alcohol/drug Abuse
  - Anxiety/depression/mental illness
  - Asthma
  - Cancer
  - Cardiac Condition/Heart Murmur
  - Coagulation Disorder
  - Concussion
  - Dental Problems
  - Diabetes
  - Endometriosis
  - Gastrointestinal Problems
  - Hepatitis B or C Disease
  - High Blood Pressure
  - HIV/AIDS
  - Measles
  - Mononucleosis
  - Mumps
  - Rheumatic Fever
  - Seizures
  - Sickle Cell Anemia
  - Thyroid Disorder
  - Tuberculosis
  - Other please explain

**Allergies: Drugs & Other Severe Adverse Reactions - Please complete all that apply and explain reaction**

- [ ] Check here if you have no allergies
  - Medication
    - Insect
    - Seasonal
    - X-ray Contrast
  - Food
    - Environmental
  - X-ray Contrast
    - Are any life threatening? [ ] Yes [ ] No
    - Do you carry an Epi Pen? [ ] Yes [ ] No

**Prior Hospitalizations or Surgeries - Please list dates and reasons**

**Medications – Frequent or regular- Please list all prescriptions, natural and over the counter medications**

**Is there any other medical information or health concern that we should know about? Please attach any additional information to further explain your condition or concern.**

**Current Height**:  
**Current Weight**:  
**Last Blood Pressure (if known)**:

**not required**

**Did you sign the Consent for Treatment on Page 1?**

Please return by mail or fax to the appropriate Health Service listed below.

<table>
<thead>
<tr>
<th>Central Connecticut State University</th>
<th>Eastern Connecticut State University</th>
<th>Southern Connecticut State University</th>
<th>Western Connecticut State University</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Health Service</td>
<td>University Health Service</td>
<td>University Health Service</td>
<td>University Health Service</td>
</tr>
<tr>
<td>1615 Stanley Street</td>
<td>185 Birch Street</td>
<td>501 Crescent Street</td>
<td>181White Street</td>
</tr>
<tr>
<td>New Britain, CT 06050</td>
<td>Willimantic, CT 06226</td>
<td>New Haven, CT 06515</td>
<td>Danbury, CT 06810</td>
</tr>
</tbody>
</table>

Revised 01/14/11
Important Instructions:
1. This form is a supplement to the Connecticut State University (CSU) Student Health form which must be completed by your Primary Healthcare Provider. Please make sure it is complete and signed by all necessary persons. Please note: immunization dates must be written on the form. Attached copies of immunization records will not be accepted.
2. The student-athlete should complete Part 1: Health Questionnaire prior to the physical examination.
3. Provide the completed Part 1 form to your healthcare provider at the time of the physical examination.
5. Healthcare provider must then complete Part 2: The Physical Examination, attach any necessary information, and sign on page three.
6. All three pages and the CSU Student Health form along with any additional information, consult letters, lab and/or radiology reports must be mailed to University Health Services, Central Connecticut State University, 1615 Stanley Street, New Britain, CT 06050.

Name: _______________________________ Date of Birth: ________________ Gender: ______

CCSU Student ID#: ___________________________ Sport(s): __________________________

Date of Exam: ________________ (NCAA requires pre-participation physical exam be completed within 6 months of the first practice)

Part 1: Health Questionnaire
(Please make sure page two of the CSU Student Health form is complete with your current medical history, medications with dosages, and allergies with reactions.)
Please explain all “Yes” responses on page 3. Circle questions you don’t know the answers to.

<table>
<thead>
<tr>
<th>Column1</th>
<th>Yes</th>
<th>No</th>
<th>Column3</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Have you ever been denied or restricted your participation in sports for a medical reason or injury?</td>
<td>2)</td>
<td>Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td>Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td>4)</td>
<td>Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td>Has a doctor ever told you that you have any heart problems or a heart murmur?</td>
<td>6)</td>
<td>Have you ever had Kawasaki disease, myocarditis, or an infection in your heart?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7)</td>
<td>Do you get tired or out of breath more quickly than you would expect given your fitness level?</td>
<td>8)</td>
<td>Do you have high blood pressure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9)</td>
<td>Do you have high cholesterol?</td>
<td>10)</td>
<td>Have you ever had an unexplained seizure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11)</td>
<td>Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td>12)</td>
<td>Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13)</td>
<td>Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td>14)</td>
<td>Have you ever had a stress fracture?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15)</td>
<td>Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?</td>
<td>16)</td>
<td>Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17)</td>
<td>Do you have a bone, muscle, or joint injury that bothers you?</td>
<td>18)</td>
<td>Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19)</td>
<td>Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td>20)</td>
<td>Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Part 1: Health Questionnaire (Continued)

**Health Questionnaire:** Please explain all “Yes” responses below. Circle questions you don’t know the answers to.

<table>
<thead>
<tr>
<th>Column1</th>
<th>Yes</th>
<th>No</th>
<th>Column3</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>21) Have you ever used an inhaler or taken asthma medicine?</td>
<td></td>
<td></td>
<td>22) Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23) Do you have groin pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
<td>24) Have you had infectious mononucleosis (mono)? (please indicate date on page 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25) Do you have any rashes, pressure sores, or other skin problems?</td>
<td></td>
<td></td>
<td>26) Have you had a herpes or MRSA skin infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27) Have you ever had a head injury or concussion?</td>
<td></td>
<td></td>
<td>28) Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29) Do you have a history of seizure disorder?</td>
<td></td>
<td></td>
<td>30) Do you have headaches with exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
<td>32) Have you ever been unable to move your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33) Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
<td>34) Do you get frequent muscle cramps when exercising?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35) Do you or someone in your family have sickle cell trait or disease?</td>
<td></td>
<td></td>
<td>36) Have you had any problems with your eyes or vision?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37) Have you had any eye injuries?</td>
<td></td>
<td></td>
<td>38) Do you wear glasses or contact lenses?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39) Do you wear protective eyewear, such as goggles or a face shield?</td>
<td></td>
<td></td>
<td>40) Do you worry about your weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41) Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
<td>42) Are you on a special diet or do you avoid certain types of foods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43) Have you ever had an eating disorder?</td>
<td></td>
<td></td>
<td>44) Do you have any concerns that you would like to discuss with a doctor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions 45 – 47: FEMALES ONLY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45) Have you ever had a menstrual period?</td>
<td></td>
<td></td>
<td>46) How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47) How many periods have you had in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” responses here. Please include dates and any tests or medical specialist visits that may be related. Please attach additional sheets if needed.

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

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

**Signature of athlete:** ___________________________  **Date:** ________________

**Signature of parent/guardian:** ___________________________  **Date:** ________________

*(If athlete is under 18)*

**To the examining healthcare provider:** Please consider further evaluation for any positive responses to questions 2-9. At the very least we may request an EKG or clear explanation as to why no further screening or diagnostic tests are warranted.

I have reviewed above Medical History and Health Questionnaire at the time of my examination of the patient named above:

**Healthcare Provider Signature:** ___________________________  **Date:** ________________

END PART 1
Part 2: Physical Examination: (To be completed by Health Care Provider)

Name _______________________________ Date of Birth: ______________ Gender: _______

Date of Exam: ________________________ (NCAA requires pre-participation physical exam be completed within 6 months of the first practice)

Note to examining Healthcare Provider: CCSU Health Services adheres to the concept of targeted cardiovascular screening for our intercollegiate athletes. Please complete the section below in detail and consider EKG, echocardiogram, and/or referral to cardiology for abnormal cardiac history or exam or for a patient with two or more Marfan stigmata. We do not emphasize the section for the musculoskeletal exam as all athletes will receive a comprehensive musculoskeletal evaluation on campus. Please add any parts of the exam you believe are indicated.

EXAMINATION

Height: ______________ Weight: ______________ BMI: ______________ BP: Left: / Right: / Pulse: ______________

Vision Right: 20/_______ Left: 20/_______ OU: 20/_______ Corrected? □ Y □ N Peak Flow or attach PFTs (if history of asthma):

MEDICAL (Please note “NE” if area not examined)

General Appearance:

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

Eyes/ears/nose/throat:

Lymph nodes:

Heart: (please auscultate sitting, supine, and with squat or valsava)
- Sitting: ______________
- Supine: ______________
- Valsalva/Squat: ______________
- PMI: ______________

Pulses- include simultaneous femoral and radial pulses:

Lungs:

Abdomen:

Genitourinary (males only):

Skin:

Neurologic:

MUSCULOSKELETAL (only perform as indicated by history and Part 1 above)

Neck:

Back:

Upper Extremities:

Lower Extremities:

Reminders: Please attach copies of EKGs, other testing, or pertinent consult notes. If none were indicated, please give detailed explanation below or attach copy of pertinent office notes. Although all athletes will have baseline neurocognitive testing (ImPact) on campus, please consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant or multiple concussions.

☐ Cleared for all sports without restriction
☐ Not cleared

Healthcare Provider notes with explanations and recommendations ______________________________________

________________________________________

I have examined the above-named student-athlete and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, clearance may be rescinded until the problem is resolved or clarified.

Signature of Healthcare Provider: _______________________________ Date: ______________

Name of Healthcare Provider (print): ______________________________________

Address: ______________________________________ Phone: ______________ Fax: ______________
IMPORTANT NOTICE TO STUDENT-ATHLETES REGARDING SICKLE CELL TRAIT TESTING

Dear Parents and CCSU Incoming Athlete,

As of August 1, 2010, the NCAA requires that prior to participation in any intercollegiate athletic event (including strength and conditioning sessions, practices, competitions, or try-outs) each new, first-time student athlete will be educated about sickle cell trait and must either show proof of a prior test for sickle cell trait, be tested for sickle cell trait, or sign a waiver releasing CCSU of liability if they decline to be tested.

Therefore, Student-Athletes need to do one of the following:

1. Provide CCSU Health Services with documentation showing your sickle cell trait status. Many states test for this routinely at birth. Contact your primary care provider (PCP) to see if they have access to a copy of this result.

   Or

2. If no report is available, discuss with your PCP having a simple blood test for the sickle cell trait. The results need to be sent to CCSU Health Services. Alternatively, you can make an appointment with University Health Services for testing.

   Or

3. Sign a waiver releasing the State of Connecticut, the University, its officers, employees and agents from any and all costs, liability, expense claims, demands or causes of action on account of any loss or personal injury that might result from your refusal to be tested. Please Note: The signing of the waiver is not recommended. It is preferred that all student-athletes know their status to help ensure their health and wellbeing during participation in athletics.

   • Prior to signing the waiver, we are advising all student-athletes to please:
   o Consult with their parent or guardian
   o View NCAA Educational Video
   o Read NCAA “A Fact Sheet for Student Athlete”

Please return either a copy of your lab report or a signed waiver form to University Health Services, preferably along with your other health forms, as soon as possible.

Sincerely,

Christopher Diamond, MD
Director of Health Services

Kathy Pirog, ATC
Head Athletic Trainer
What is Sickle Cell Trait?

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or “sickle” shape), which can accumulate in the bloodstream and “logjam” blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood.
- Likely sickling settings include timed runs, all out exertion of any type for 2 – 3 continuous minutes without a rest period, intense drills and other spurts of exercise after prolonged conditioning exercises, and other extreme conditioning sessions.
- Common signs and symptoms of a sickle cell emergency include, but are not limited to: increased pain and weakness in the working muscles (especially the legs, buttocks, and/or low back); cramping type pain of muscles; soft, flaccid muscle tone; and/or immediate symptoms with no early warning signs.

For Athletes Confirmed Positive For The Sickle Cell Trait, The Following Reasonable Precautions Will Be Taken In Order To Appropriately Manage This Condition:

- The student athlete will slowly build up the intensity and duration of their training with paced progressions. This will also include longer periods for rest and recovery.
- The student athlete will participate in pre-season conditioning programs in order to prepare them for the rigors of their competitive seasons.
- The student athlete may have modified performance tests such as mile runs, serial sprints, etc.
- The student athlete will stop all activity and seek medical evaluation with the onset of symptoms such as “muscle cramping,” pain, swelling, weakness, tenderness, undue fatigue, or the inability to “catch breath.”
- The student athlete will be given the opportunity to set their own pace during conditioning drills.
- The student athlete’s participation may be altered during periods of heat stress, dehydration, asthma, illness, or activity in high altitudes.

Resources for more information:

Athlete Please Note: After reviewing the information provided regarding sickle cell trait and sickle cell testing, you are electing not to be tested for sickle cell trait or provide lab results from previous tests by signing and submitting this “Sickle Cell Trait Waiver Form”.

About Sickle Cell Trait

• Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
• Sickle cell trait is a common condition (> three million Americans)
• Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
• Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or “sickle” shape), which can accumulate in the bloodstream and “logjam” blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood.

Sickle Cell Trait Testing: The NCAA mandates that all student-athletes have knowledge of their sickle cell trait status, show proof of a prior test or sign a testing waiver before the student-athlete participates in any intercollegiate athletics event, including strength and conditioning sessions, practices, competitions, etc.

SICKLE CELL TRAIT TESTING WAIVER

I, _______________________________, understand and acknowledge that the NCAA mandates that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts and the University policy about sickle cell trait and sickle cell trait testing.

Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to Central Connecticut State University Health Services and Sports Medicine personnel.

I do not wish to undergo sickle cell trait testing and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Connecticut, the University, its officers, employees, agents and their successors and assigns from any and all costs, claims, damages or expenses, including attorneys fees, arising from any loss or personal injury that might result from my non-compliance with the mandate of the NCAA.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

_________________________________________________  ___________________
Student-Athlete Signature       Date

_________________________________________________
Athlete’s Print Name

_________________________________________________
Sport

_________________________________________________  ___________________
Parent/Guardian’s Signature (if under 18 years of age)       Date

_________________________________________________
Parent/Guardian’s Print Name