Student Wellness Services-Health

Welcome Varsity Athlete,

As your health and safety are of the utmost importance you must receive medical clearance from our office, CCSU Student Wellness Services-Health, prior to participating in our varsity athletic program. Our medical clearance process requires you to complete the following five steps:

1. Completion of the Connecticut State University Student Health Services’ Form (Grey)
2. Completion of the CCSU Varsity Athletics: Supplemental Student Health Services’ Form (Blue)
3. Submission of results of testing for sickle cell trait or a signed waiver opting out of the testing (Pink)
4. **SUBMIT YOUR MEDICAL FORMS to CCSU Student Wellness Services-HEALTH**
5. Appointment with Student Wellness Services-Health for University Clearance after your Sports Physical with your physician.

**Detailed instructions for each of these steps are below:**

**Step 1**
Completion of the Connecticut State University Student Health Services’ Form (Grey)

All students are required to submit a completed *Connecticut State University Student Health Services Form* prior to matriculating. On page one you are required to enter the dates of immunization against measles, mumps, rubella (MMR) and varicella (chicken pox), or provide proof of immunity (please attach lab test results). Please note, that all student-athletes must have up-to-date immunizations against tetanus (within the last ten years and preferably the last seven), meningitis (must be a quadrivalent vaccine such as Menactra), and hepatitis B (vaccination against hepatitis A is also recommended). On the first page is a required Tuberculosis (TB) Risk Assessment. **Please make sure to answer all questions in section 6.** On page two please provide your past medical and surgical history, along with an accurate and complete list of your medications and allergies.

**Step 2**
Completion of the CCSU Varsity Athletics: Supplemental Student Health Services’ Form (Blue)

Your sport pre-participation physical exam must be conducted by your primary care provider (PCP) please secure an appointment with their office as soon as possible.

Pages one and two are a health questionnaire that you must complete prior to your sport pre-participation physical examination (PPE) with your PCP. You may need assistance from your parent(s)/guardian(s) to complete this form, as an accurately completed history form is essential to this process. **Page three is the physical examination form, to be completed by your PCP.** Please note that we will not accept any other forms or copies of records in lieu of these forms. If any form is incomplete or we have questions, we will call you.

You can avoid delays in being medically cleared to participate in your sport by completing all necessary medical assessments at home, and submitting documents to Student Wellness Services-Health in a timely fashion.

- Your PCP may recommend further testing/labs for any conditions found at the time of your PPE exam. **Please make arrangements to have the recommended testing/labs done at home before your anticipated date of arrival.** Since many times insurances will not cover out of state providers/and or services, it is important to have all testing done prior to your arrival at CCSU.

- If in the past, you have had any diagnostic tests i.e. cardiac, respiratory, or any other medical workups, then results must be submitted with your forms. **Failure to submit these results will delay your medical clearance to participate in your sport.**
Step 3
Submission of results of testing for sickle cell trait or a signed waiver opting out of the testing (Pink)
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 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. CCSU strongly urges you to know your sickle cell trait status. Most states started screening all newborns by 1990. Please contact your primary care provider to get a copy of your newborn screen or to have them order a new sickle cell screening test.

Step 4
SUBMITTING YOUR MEDICAL FORMS (Preferred Method is to MAIL the forms)
   A. Please retain a copy of all forms for your own records
   B. Mail forms (Grey, Pink, Blue) along with supporting medical documents directly to:
      Student Wellness Services-HEALTH
      Central CT State University
      Marcus White Hall
      1615 Stanley Street
      New Britain, CT 06050

DO NOT email, fax, mail or give medical health forms to coaches to submit for you. Your coaches should not request or be provided with copies of any of your personal medical health forms.

Step 5
Appointment with Student Wellness Services – Health
Once all of the above steps are completed and sent to CCSU, please call our office to schedule your “University SPORT CLEARANCE” appointment with a CCSU Healthcare Provider at 860-832-1925. At your Sport Clearance appointment with one of our providers, all the above information will be reviewed. We may repeat parts or all of the physical exam, require further or repeat testing, or even require specialty medical consultation prior to granting medical clearance.

We are very happy you are joining us at Central Connecticut State University. All of us in Student Wellness Services-Health are here to help you succeed in your academic and athletic career at CCSU. Please contact us at 860-832-1925 if you have questions or require special considerations.

Wishing you a healthy, successful, and safe varsity season.

Marisol Aponte, APRN Associate Director
Central Connecticut State University
Student Wellness Services - Health
These blue pages are to be submitted as a supplement to the Connecticut State University (CSU) Student Health form which is required for all students. The CSU form must be completed by your Primary Healthcare Provider (PCP) and must be complete and signed by all necessary persons. Please note: immunization dates must be written on the CSU form. Attached copies of immunization records will not be accepted.

Name: ________________________________ Date of Birth: ____________ Gender: ________

CSU Student ID#: ____________________________ Sport(s): ____________________________

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

Instructions (read carefully):
1. You should complete Part 1: Health Questionnaire prior to your pre-participation physical examination (PPE)*.
2. Your PCP must review and sign Part 1 at the time of your examination.
3. Your PCP must then complete Part 2: The Physical Examination, attach any necessary information, and sign on page three.
4. 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 Student Wellness Services-Health, Central Connecticut State University, 1615 Stanley Street, New Britain, CT 06050.

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>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td>2)</td>
<td></td>
</tr>
<tr>
<td>Have you ever been denied or restricted your participation in sports for a medical reason or injury?</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></td>
<td>4)</td>
<td></td>
</tr>
<tr>
<td>Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td>Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
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<tr>
<td>5)</td>
<td></td>
<td>6)</td>
<td></td>
</tr>
<tr>
<td>Has a doctor ever told you that you have any heart problems or a heart murmur?</td>
<td>Have you ever had Kawasaki disease, myocarditis, or an infection in your heart?</td>
<td></td>
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<tr>
<td>7)</td>
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<td>8)</td>
<td></td>
</tr>
<tr>
<td>Has any family member or relative died unexpectedly or of a heart problem before age 50?</td>
<td>Has anyone in your family had unexplained fainting, unexplained seizures, near drowning, or been diagnosed with a chronic or congenital disease?</td>
<td></td>
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<tr>
<td>9)</td>
<td></td>
<td>10)</td>
<td></td>
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<tr>
<td>Do you get tired or out of breath more quickly than you would expect given your fitness level?</td>
<td>Do you have high blood pressure?</td>
<td></td>
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<tr>
<td>11)</td>
<td></td>
<td>12)</td>
<td></td>
</tr>
<tr>
<td>Do you have high cholesterol?</td>
<td>Have you ever had an unexplained seizure?</td>
<td></td>
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<tr>
<td>13)</td>
<td></td>
<td>14)</td>
<td></td>
</tr>
<tr>
<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>Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
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<tr>
<td>15)</td>
<td></td>
<td>16)</td>
<td></td>
</tr>
<tr>
<td>Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, acast, or crutches?</td>
<td>Have you ever had a stress fracture?</td>
<td></td>
<td></td>
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<tr>
<td>17)</td>
<td></td>
<td>18)</td>
<td></td>
</tr>
<tr>
<td>Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?</td>
<td>Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19)</td>
<td></td>
<td>20)</td>
<td></td>
</tr>
<tr>
<td>Do you have a bone, muscle, or joint injury that bothers you?</td>
<td>Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Question</td>
</tr>
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<td>------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21) Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td></td>
<td></td>
<td>22) Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
</tr>
<tr>
<td>23) Have you ever used an inhaler or taken asthma medicine?</td>
<td></td>
<td></td>
<td>24) Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
</tr>
<tr>
<td>25) Do you have groin pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
<td>26) Have you had infectious mononucleosis (mono)? (please indicate date on page 3)</td>
</tr>
<tr>
<td>27) Do you have any rashes, pressure sores, or other skin problems?</td>
<td></td>
<td></td>
<td>28) Have you had a herpes or MRSA skin infection?</td>
</tr>
<tr>
<td>29) Have you ever had a head injury or concussion?</td>
<td></td>
<td></td>
<td>30) Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
</tr>
<tr>
<td>31) Do you have a history of seizure disorder?</td>
<td></td>
<td></td>
<td>32) Do you have headaches with exercise?</td>
</tr>
<tr>
<td>33) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
<td>34) Have you ever been unable to move your arms or legs after being hit or falling?</td>
</tr>
<tr>
<td>35) Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
<td>36) Do you get frequent muscle cramps when exercising?</td>
</tr>
<tr>
<td>37) Do you or someone in your family have sickle cell trait or disease?</td>
<td></td>
<td></td>
<td>38) Have you had any problems with your eyes or vision?</td>
</tr>
<tr>
<td>39) Have you had any eye injuries?</td>
<td></td>
<td></td>
<td>40) Do you wear glasses or contact lenses?</td>
</tr>
<tr>
<td>41) Do you wear protective eyewear, such as goggles or a face shield?</td>
<td></td>
<td></td>
<td>42) Do you worry about your weight?</td>
</tr>
<tr>
<td>43) Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
<td>44) Are you on a special diet or do you avoid certain types of foods?</td>
</tr>
<tr>
<td>45) Have you ever had an eating disorder?</td>
<td></td>
<td></td>
<td>46) Do you have any concerns that you would like to discuss with a doctor?</td>
</tr>
<tr>
<td>Questions 45 – 47: FEMALES ONLY</td>
<td></td>
<td></td>
<td>47) Have you ever had a menstrual period?</td>
</tr>
<tr>
<td>48) How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
<td>49) How many periods have you had in the last 12 months?</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: ________________
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 Student Wellness Services-Health 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


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 valsala)

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:

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.

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

Signature of Healthcare Provider: __________________________ Date: ___________

Name of Healthcare Provider (print): ________________________________

Address: ________________________________ Phone: ______________ Fax: _____________
Connecticut State University Student Health Services Form Instructions

Connecticut General Statute and CCSU requires the following information for all matriculated students (full and part time). Please submit this form to CCSU Student Wellness Services - Health no later than **July 15** for the Fall semester and **December 15** for the Spring semester. **Failure to submit the required form will result in a health hold on your student account.**

Proof of immunity to **Measles (Rubeola)**: you must provide proof of one of the following:
Two measles or two MMR immunizations (1st dose on or after your 1st birthday; second dose at least 28 days later); **OR**
Lab results showing a positive measles titer (blood test) Please submit a copy of the test results with health form.

Proof of immunity to **Rubella**: you must provide proof of one of the following:
Two rubella or two MMR immunizations (1st dose on or after your 1st birthday; second dose at least 28 days later); **OR**
Lab results showing a positive rubella titer (blood test) Please submit a copy of the test results with health form.

Proof of immunity to **Mumps**: you must provide proof of one of the following:
Two mumps or two MMR immunizations (1st dose on or after your 1st birthday; second dose at least 28 days later); **OR**
Lab results showing a positive mumps titer (blood work) Please submit copy of the test results with health form.

Proof of immunity to **Varicella** (chicken pox): you must provide proof of one of the following:
Two varicella immunizations (second dose at least 28 days after the first dose); **OR**
Lab results showing a positive varicella titer (blood test) Please submit copy of the test results with health form.

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

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.** The vaccine must have been administered within five years before enrollment.

**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** *(while not required it is strongly recommended)*.

**Tetanus**: A booster shot is recommended every ten years.

**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/healthservice/forms](http://www.ccsu.edu/healthservice/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.*

Please check your Central Pipeline account at least 5 days after submitting the required information. Your Central Pipeline account will indicate the MISSING information under the “Registration Status” Section. If you have a health hold and nothing is indicated as to what is missing, we have not received ANY information for you.

CCSU Student Wellness Services – Health
860-832-1925 (Phone) 860-832-2579 (Fax) [www.ccsu.edu/Healthservices](http://www.ccsu.edu/Healthservices)
Connecticut State University Student Health Services Form

State of Connecticut and Connecticut State Universities REQUIRE:

**Two doses for each Measles, Mumps, Rubella & Varicella**  
**One dose of Meningitis**  
**Complete TB Risk and/or Test or Treatment**

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

- **Varicella is required only for students born on or after January 1, 1980**
  1. #1 Must be on or after 1st birthday;
  2. #2 Must be at least 28 days after 1st immunization

5. **Meningooccal** (must include groups A, C, Y&W-135) If living on-campus, your most recent vaccination must be within 5 years of your 1st day of classes at the University. Please note: You will not be permitted to move in to campus housing without first providing the Student Health Service with this information.

Date(s): 1. 2. ___________  
Brand of Vaccine: ___________  
I will not be living on-campus. I do not require this vaccine.

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6. 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? If you answer, “Yes,” Section 6b., “CHEST X-RAY”, must be completed  
   Yes  
   No

B. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?  
   Yes  
   No

C. Were you born in one of the countries listed below?  
   Yes  
   No

D. Have you traveled or lived for more than one month in one or more of the countries listed below?  
   Yes  
   No

---

6a. **TB BLOOD TEST**  
   Interferon-gamma release assay release  
   Date: ___________  
   Result: Neg  
   Pos

6a. **TB SKIN TEST**  
   Use STU Mantoux test only.  
   Date Planted: ___________  
   Date Read: ___________  
   Interpretation (if no induration, mark 0)  
   NEG  
   POS

6b. **CHEST X-RAY**  
   Required within the past 12 months for a previous or current positive TB skin or blood test. Copy of X-ray report **MUST be attached.** X-ray is not needed if asymptomatic AND completed full course of treatment for the positive TB test (latent TB).  
   Chest X-ray Date: ___________  
   Frequency: ___________  
   Start & Completion Dates: ___________

---

6c. **TB TREATMENT MEDICATION (with dose):**

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**Other Vaccination History**

- Tetanus Booster within last 10 years and Hepatitis B series are recommended if not already completed

**Hepatitis B #1**  
Date: ___________  
Hepatitis B #2  
Date: ___________  
Hepatitis B #3  
Date: ___________  
Hepatitis Titer Date: ___________  
Result: POS  
NEG

---

Signatures

**I confirm that the information above is accurate.**

Clinician Signature: ___________  
Date: ___________

Student consent for treatment required to be signed:  
(If you are less than 18 years of age signates of both the student and one parent/guardian are required)

---

I hereby grant permission for the Connecticut State University Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions. Furthermore, I understand that University Health Services staff may disclose my student medical records and/or information from such records to appropriate University personnel and/or Emergency Contacts identified within my records in the event of a health or safety situation as determined by the Student Health Services staff.

Signature of Student: ___________  
Date: ___________

Signature of Parent/Guardian: ___________  
Date: ___________
## Connecticut State University Student Health Services Form

### 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>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

### Notify in Case of Emergency

<table>
<thead>
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<th>Home Phone</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
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<th>Zip</th>
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</table>

### Personal Physician/Healthcare Provider

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

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

- Alcohol/Substance Abuse
- Dental Problems
- Mononucleosis
- Anemia
- Diabetes
- Mumps
- Anxiety/Depression/Mental illness
- Gastrointestinal Conditions/IBS
- Rheumatic Fever
- Asthma
- Gynecological Conditions
- Seizures
- Cancer
- Hepatitis B or C Disease
- Sickle Cell Disease
- Cardiac Condition/Heart Murmur
- High Blood Pressure
- Thyroid Disorder
- Coagulation/Bleeding Disorder
- HIV/AIDS
- Tuberculosis
- Concussion
- Measles
- Other – please explain

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

- Medication
- Food
- Insect
- Environmental
- Seasonal
- 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(s) or concern(s).

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

**not required**

### Student - Did you sign the Consent for Treatment on Page 1?

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

- Central Connecticut State University
  - University Health Services
  - 1615 Stanley Street
  - New Britain, CT 06050
  - 860/832-1925 Fax 860/832-2579

- Eastern Connecticut State University
  - University Health Services
  - 185 Birch Street
  - Willimantic, CT 06226
  - 860/465-5263 Fax 860/465-4560

- Southern Connecticut State University
  - University Health Services
  - 501 Crescent Street
  - New Haven, CT 06515
  - 203/392-6300 Fax 203/392-6301

- Western Connecticut State University
  - University Health Services
  - 181 White Street
  - Danbury, CT 06810
  - 203/837-8594 Fax 203/837-8583
Central Connecticut State University
Student Wellness Services - Health
&
Department of Intercollegiate Athletics
Joint Sickle Cell Trait Waiver Form

**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.

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**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

CCSU Sickle Cell Waiver_ April2017

Tracking: _____ On File Student Wellness-Health         _____ Copy to Sports Medicine