Welcome Varsity Athlete,

As your health and safety are of the utmost importance you must receive medical clearance from our office, University Health Services, 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;
2) Completion of the CCSU Varsity Athletics: Supplemental Student Health Services’ Form;
3) Submission of results of testing for sickle cell trait or a signed waiver opting out of the testing;
4) Baseline Neuro-cognitive testing (ImPact); and
5) Appointment with University Health Services.

Detailed instructions for each of these steps are below.

**Step 1: Completion of the Connecticut State University Student Health Services’ Form (grey)**
All full time 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 to provide proof of immunity (lab test results). Please note, though not required, student-athletes should 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). Also on the first page is a required Tuberculosis (TB) Risk Assessment. 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)**
Pages one and two are a health questionnaire that you must complete prior to your pre-participation physical examination. Page three is the physical examination form. Your pre-participation physical exam must be conducted either by your primary care provider (PCP) or a provider at CCSU Health Services. Please call us at 860-832-1925 in order to schedule an exam with us. Make sure you complete the health questionnaire prior to your appointment (regardless whether it is done with your PCP or with us) as it must be reviewed and signed by the healthcare provider conducting your physical. You may need assistance from your parent(s)/guardian(s) to complete this form. An accurately completed history form is essential to this process. You cannot receive medical clearance without it.

If your PCP is completing your pre-participation physical examination, please make sure your form is complete and legible. If further testing is recommended or indicated (such as a cardiology evaluation or asthma testing), these results must be attached to the form prior to returning it to us. 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 may call you to schedule a pre-participation exam at University Health Services.
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.

Steps 4 & 5: Baseline Neuro-cognitive testing (ImPact) and Appointment with University Health Services (If you had you PPE done here, then this final step may not be necessary)

Once all of the above steps are completed and collected, please call our office to schedule ImPact testing and an appointment with our medical director or one of our other providers at 860-832-1925. You may also be given an appointment to meet with our athletic training staff on the same day.

As part of the CCSU Intercollegiate Athletics’ Concussion Policy and Procedures, all new student-athletes must complete baseline neuro-cognitive testing prior to the first practice. We use a computerized program, ImPact, which measures visual and verbal memory, reaction time and cognitive processing speed. This baseline test is used for comparison if you ever sustain a concussion or head injury.

At your 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 CCSU. All of us in University Health Services 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,

Christopher Diamond, MD
Director, Student Wellness Services
Connecticut State University Student Health Services Form

This Connecticut State University Student Health Services Form is mandatory and the only form that will be accepted as proof of vaccination. All information must be entered on the form. Entering or stamping, “See Attached,” may delay the processing of your form. We encourage attaching immunization records but dates must be entered on form. Please make this clear to your healthcare provider’s office when you drop off the form.

All students, including transfer and exchange students, and those changing from part-time to full-time status, 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. Part-time students are not required to have a clinician signature on the “Physical Examination Affirmation.” Page two is also optional for part-time students.

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 6/14/14
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 1st 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 1st 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 1st 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) within five years of entering CCSU is required for all residential students prior to room assignment. No student may move into campus housing until this requirement is met. Even if not living on-campus, we 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.

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.

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

Revised 06/19/14
Connecticut State University Student Health Services Form

Date Beginning School □ Fall □ Spring of

PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED

Signature of Student
Consent for treatment required to be signed

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:

Hepatitis B #1

Date:

Date: Date

Hepatitis B #2

Date:

Hepatitis B #3

Date:

Hepatitis Titer

Result: POS NEG

Last Tetanus Booster: TD or Tdap

Date:

Other Vaccination History (Tetanus Booster within last 10 years and Hepatitis B series are recommended)

Date of Birth and Birthplace:

Sex/Gender:

Student ID #: □ □ □ □ □ □ □ □ □

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

Vaccine & Date Given

Incidence of Disease

Titer Test Results (attach lab report)

Requirements

1 Measles #1 □ or MMR □ Date:

Measles Titer Date:

Result □ Pos □ Neg

2 Mumps #1 □ or MMR □ Date:

Mumps Titer Date:

Result □ Pos □ Neg

3 Rubella #1 □ or MMR □ Date:

Rubella Titer Date:

Result □ Pos □ Neg

4 Varicella #1 □ or MMR □ Date:

Varicella Titer Date:

Result □ Pos □ Neg

Varicella is required only for students born on or after January 1, 1980

#1 Must be on or after 1st birthday;

#2 Must be at least 28 days after 1st immunization

Meningococcal (must include groups A,C,Y&W-135) If living on-campus, your last vaccination must be within 5 years of your 1st day of school.

Date(s): 1._________ 2._________

Brand of Vaccine: ______________________

□ I will not be living on-campus. I do not require this vaccine.

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? If yes circle country

Yes □ No □

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

Yes □ No □

Other Vaccination

Date

Interferon-gamma release assay

Date:

Result: NEG POS

6a. TB SKIN TEST Use STU Mantoux test only.

Date Planted: □ NEG □ POS

Date Read:

Interpretation (if no induration, mark 0)

mm of induration

Chest X-ray Date:

□ Normal □ Abnormal

6b. CHEST X-RAY Required within 1 year for past or current positive TB skin or blood test. X-ray report MUST BE ATTACHED

6c. TB TREATMENT MEDICATION (with dose):

Prior BCG does not exempt patient from this requirement.

IF you answer YES to B-D of the above questions, Connecticut State University requires that a healthcare provider complete the TB testing evaluation and x-ray within 6 months prior to the start of classes.

After February for Fall Semester and July for Spring Semester.

Other Vaccination

Hepatitis B #1

Date:

Hepatitis B #2

Date:

Hepatitis B #3

Date:

Hepatitis Titer

Result: POS NEG

Last Tetanus Booster: TD or Tdap

Date:

Other Vaccination:

Other Vaccination:

Other Vaccination:

Signatures

I confirm that the information above is accurate.

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)

If 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

Signature of Parent/Guardian

Date:
## Connecticut State University Student Health Services Form

**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>
</tr>
</thead>
</table>

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

### Personal Physician/Healthcare Provider

<table>
<thead>
<tr>
<th>Personal Physician/Healthcare Provider</th>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone #</th>
<th>FAX #</th>
</tr>
</thead>
</table>

### 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
- 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 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.

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

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

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

**Western Connecticut State University**
University Health Service
181 White Street
Danbury, CT 06810
203/837-8594 Fax 203/837-8583

Revised 06/19/2014
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: ________
CCSU 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 University Health Services, Central Connecticut State University, 1615 Stanley Street, New Britain, CT 06050. * CCSU Student Wellness Services can provide your PPE if needed. Call 860-832-1925.

**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>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Have you ever been denied or restricted your participation in sports for a medical reason or injury?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
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<tr>
<td>3) Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
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<tr>
<td>4) Does your heart ever race or skip beats (irregular beats) during exercise?</td>
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<tr>
<td>5) Has a doctor ever told you that you have any heart problems or a heart murmur?</td>
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<tr>
<td>6) Have you ever had Kawasaki disease, myocarditis, or an infection in your heart?</td>
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<tr>
<td>7) Has any family member or relative died unexpectedly or of a heart problem before age 50?</td>
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<tr>
<td>8) Has anyone in your family had unexplained fainting, unexplained seizures, near drowning, or been diagnosed with a chronic or congenital disease?</td>
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<tr>
<td>9) Do you get tired or out of breath more quickly than you would expect given your fitness level?</td>
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<tr>
<td>10) Do you have high blood pressure?</td>
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<tr>
<td>11) Do you have high cholesterol?</td>
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<td></td>
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<tr>
<td>12) Have you ever had an unexplained seizure?</td>
<td></td>
<td></td>
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<tr>
<td>13) Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
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<td></td>
</tr>
<tr>
<td>14) Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
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<tr>
<td>15) Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
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<tr>
<td>16) Have you ever had a stress fracture?</td>
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<tr>
<td>17) Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?</td>
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<tr>
<td>18) Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
<td></td>
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<tr>
<td>19) Do you have a bone, muscle, or joint injury that bothers you?</td>
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<td></td>
</tr>
<tr>
<td>20) Do any of your joints become painful, swollen, feel warm, or look red?</td>
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<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>21) Do you have any history of juvenile arthritis or connective tissue disease?</td>
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<tr>
<td>23) Have you ever used an inhaler or taken asthma medicine?</td>
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<tr>
<td>25) Do you have groin pain or a painful bulge or hernia in the groin area?</td>
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<tr>
<td>27) Do you have any rashes, pressure sores, or other skin problems?</td>
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<tr>
<td>29) Have you ever had a head injury or concussion?</td>
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<tr>
<td>31) Do you have a history of seizure disorder?</td>
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<tr>
<td>33) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?</td>
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<tr>
<td>35) Have you ever become ill while exercising in the heat?</td>
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<tr>
<td>37) Do you or someone in your family have sickle cell trait or disease?</td>
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</tr>
<tr>
<td>39) Have you had any eye injuries?</td>
<td></td>
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<tr>
<td>41) Do you wear protective eyewear, such as goggles or a face shield?</td>
<td></td>
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<tr>
<td>43) Are you trying to or has anyone recommended that you gain or lose weight?</td>
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</tr>
<tr>
<td>45) Have you ever had an eating disorder?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Questions 45 – 47: FEMALES ONLY**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>47) Have you ever had a menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48) How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49) How many periods have you had in the last 12 months?</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

2
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**

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>BMI:</th>
<th>BP: Left:</th>
<th>/</th>
<th>Right:</th>
<th>/</th>
<th>Pulse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Right: 20/_______</td>
<td>Left: 20/_______</td>
<td>OU: 20/_______</td>
<td>Corrected? □ Y □ N</td>
<td>Peak Flow or attach PFTs (if history of asthma):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 valsalva)

<table>
<thead>
<tr>
<th>Sitting:</th>
<th>Supine:</th>
<th>Valsalva/Squat:</th>
<th>PMI:</th>
</tr>
</thead>
</table>

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: ________________
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
       http://web1.ncaa.org/web_video/health_and_safety/sickle_cell/sickleCell.html
     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                              Kathy Pirog, ATC
Director of Health Services                           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:**

NCAA  
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