Dear 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 Form)

All matriculated students are required to submit a completed Connecticut State University Student Health Services Form. 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 Form)

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). Make sure you complete the health questionnaire prior to your appointment 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.

When your PCP completes your form, 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 Form)

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

Once Steps have been completed your paperwork will be reviewed. Please call our office at 860-832-1925, Option 1 to schedule your ImPact testing and sports clearance appointment with one of our providers. 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.

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

Marisol Aponte, APRN
Associate Director
Student Wellness Services - University Health Services
CCSU Varsity Athletics: Supplemental Student Health Services’ Form

PRE-PARTICIPATION PHYSICAL EVALUATION

Part 1: Health Questionnaire
Part 2: Physical Examination

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 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>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>2) Have you ever passed out or nearly passed out during or after exercise?</td>
</tr>
<tr>
<td>3) Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td>4) Does your heart ever race or skip beats (irregular beats) during exercise?</td>
</tr>
<tr>
<td>5) Has a doctor ever told you that you have any heart problems or a heart murmur?</td>
<td>6) Have you ever had Kawasaki disease, myocarditis, or an infection in your heart?</td>
</tr>
<tr>
<td>7) Has any family member or relative died unexpectedly or of a heart problem before age 50?</td>
<td>8) Has anyone in your family had unexplained fainting, unexplained seizures, near drowning, or been diagnosed with a chronic or congenital disease?</td>
</tr>
<tr>
<td>9) Do you get tired or out of breath more quickly than you would expect given your fitness level?</td>
<td>10) Do you have high blood pressure?</td>
</tr>
<tr>
<td>11) Do you have high cholesterol?</td>
<td>12) Have you ever had an unexplained seizure?</td>
</tr>
<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>
<td>14) Have you ever had any broken or fractured bones or dislocated joints?</td>
</tr>
<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>
<td>16) Have you ever had a stress fracture?</td>
</tr>
<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>
<td>18) Do you regularly use a brace, orthotics, or other assistive device?</td>
</tr>
<tr>
<td>19) Do you have a bone, muscle, or joint injury that bothers you?</td>
<td>20) Do any of your joints become painful, swollen, feel warm, or look red?</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>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>21) Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22) Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23) Have you ever used an inhaler or taken asthma medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24) 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>25) Do you have groin pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26) Have you had infectious mononucleosis (mono)? (please indicate date on page 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27) Do you have any rashes, pressure sores, or other skin problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28) Have you had a herpes or MRSA skin infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29) Have you ever had a head injury or concussion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30) 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>31) Do you have a history of seizure disorder?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32) Do you have headaches with exercise?</td>
<td></td>
<td></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>
</tr>
<tr>
<td>34) Have you ever been unable to move your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35) Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36) Do you get frequent muscle cramps when exercising?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37) Do you or someone in your family have sickle cell trait or disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38) Have you had any problems with your eyes or vision?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39) Have you had any eye injuries?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40) Do you wear glasses or contact lenses?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41) Do you wear protective eyewear, such as goggles or a face shield?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42) Do you worry about your weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43) Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44) Are you on a special diet or do you avoid certain types of foods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45) Have you ever had an eating disorder?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46) Do you have any concerns that you would like to discuss with a doctor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Questions 45 – 47: FEMALES ONLY</strong></td>
<td></td>
<td></td>
</tr>
<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 EKGs, 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>Right: /</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>
</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)

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 Student Wellness Services-University Health Services 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.

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.

Student Wellness Services – University Health Services
860-832-1925 (Phone) 860-832-2579 (Fax) 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*

<table>
<thead>
<tr>
<th>Vaccine &amp; Date Given</th>
<th>Incidence of Disease</th>
<th>Titer Test Results</th>
<th>Complete TB Risk and/or Test or Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles #1</td>
<td>or MMR</td>
<td>Measles Titer</td>
<td><strong>Must be</strong> on or after 1st birthday. <strong>Must be</strong> on or after 1st birthday. <strong>Must be</strong> at least 28 days after 1st immunization. <strong>Must be</strong> at least 28 days after 1st immunization. <strong>Must be</strong> at least 28 days after 1st immunization. <strong>Must be</strong> at least 28 days after 1st immunization.</td>
</tr>
<tr>
<td>Date</td>
<td>or MMR</td>
<td>Date</td>
<td>Result: Pos Neg</td>
</tr>
<tr>
<td>Mumps #2</td>
<td>or MMR</td>
<td>Mumps Titer</td>
<td>Pos Neg Pos Neg</td>
</tr>
<tr>
<td>Date</td>
<td>or MMR</td>
<td>Date</td>
<td>Result: Pos Neg</td>
</tr>
<tr>
<td>Rubella #1</td>
<td>or MMR</td>
<td>Rubella Titer</td>
<td>Pos Neg Pos Neg</td>
</tr>
<tr>
<td>Date</td>
<td>or MMR</td>
<td>Date</td>
<td>Result: Pos Neg</td>
</tr>
<tr>
<td>Varicella #1</td>
<td>or Chicken Pox Disease</td>
<td>Varicella Titer</td>
<td>Varicella is required only for students born on or after January 1, 1980 #1 Must be on or after 1st birthday; #2 Must be on or after 1st birthday;</td>
</tr>
<tr>
<td>Date</td>
<td>or Chicken Pox Disease</td>
<td>Date</td>
<td>Provider initials:</td>
</tr>
</tbody>
</table>

**Meningococcal** (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):**

**2. Brand of Vaccine:**

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

### 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?**

<table>
<thead>
<tr>
<th>If you answer, “Yes,” Section 6b. “CHEST X-RAY” must be completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**B. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?**

<table>
<thead>
<tr>
<th>If you answer Yes circle country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>If yes circle country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>If yes circle country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**6. Prior BCG does not exempt patient from this requirement.**

**If you answer NO to all questions no further action is required.**

**If you answer YES to B-D of the above questions, Connecticut State University requires that a healthcare provider complete the following TB testing evaluation.**

#### 6a. TB BLOOD TEST

**OR Interferon-gamma release assay**

<table>
<thead>
<tr>
<th>Date</th>
<th>Result: NEG</th>
<th>POS</th>
</tr>
</thead>
</table>

#### 6a. TB SKIN TEST

**Use STU Mantoux test only.**

<table>
<thead>
<tr>
<th>Date Planted:</th>
<th>Interpretation (if no induration, mark 0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Read:</td>
<td>NEG</td>
</tr>
</tbody>
</table>

**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 required if asymptomatic AND completed full course of treatment for the positive TB test (latent TB).**

<table>
<thead>
<tr>
<th>Chest X-ray Date:</th>
<th>Results: Normal</th>
<th>Abnormal (Attach copy of report)</th>
</tr>
</thead>
</table>

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

**Frequency:**

**Start & Completion Dates:**

### Other Vaccination History (Tetanus Booster within last 10 years and Hepatitis B series are recommended if not already completed)

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

**Last Tetanus Booster: Td  or Tdpa  Other Vaccination:**

**Other Vaccination:**

### Signatures

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

**Clinician Signature:**

**Date:**

**Student consent form to be signed**

(If you are less than 18 years of age signatures 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.)
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>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Permanent Home Information**

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

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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</table>

**Personal Physician/Healthcare Provider**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Telephone #:</th>
<th>FAX #</th>
</tr>
</thead>
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**Personal Medical History - Please circle all below that apply to you.**

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

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<th>Medication</th>
<th>Food</th>
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<th>Seasonal</th>
<th>X-ray Contrast</th>
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**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
15 Birch Street
Willimantic, CT 06226
860/465-5265 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 203/837-818
Central Connecticut State University
Intercollegiate Athletics
Sports Medicine
Sickle Cell Trait Policy

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” http://web1.ncaa.org/web_files/health_safety/SickleCellTraitforSA.pdf

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,

Marisol Aponte, APRN
Associate Director
Student Wellness Services – University Health Services

Kathy Pirog, ATC
Intercollegiate Athletics
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
Central Connecticut State University
University Health Services
&
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.

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