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 quadravalent 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
Willard-DiLoreto W101
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.

Dr. Marisol Ostrov, APRN, Ed.D.
Central Connecticut State University
Student Wellness Services - Health

CCSU Varsity Athletics: Supplemental Student Wellness Services-Health

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**:________

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 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.

	Yes	No		Yes	No
1) Have you ever been denied or restricted your participation in sports for a medical reason or injury?			2) Have you ever passed out or nearly passed out DURING or AFTER exercise?		
3) Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			4) Does your heart ever race or skip beats (irregular beats) during exercise?		
5) Has a doctor ever told you that you have any heart problems or a heart murmur?			6) Have you ever had Kawasaki disease, myocarditis, or an infection in your heart?		
7) Has any family member or relative died unexpectedly or of a heart problem before age 50?			8) Has anyone in your family had unexplained fainting, unexplained seizures, near drowning, or been diagnosed with a chronic or congenital disease?		
9) Do you get tired or out of breath more quickly than you would expect given your fitness level?			10) Do you have high blood pressure?		
11) Do you have high cholesterol?			12) Have you ever had an unexplained seizure?		
13) Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			14) Have you ever had any broken or fractured bones or dislocated joints?		
15) Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			16) Have you ever had a stress fracture?		
17) Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?			18) Do you regularly use a brace, orthotics, or other assistive device?		
19) Do you have a bone, muscle, or joint injury that bothers you?			20) Do any of your joints become painful, swollen, feel warm, or look red?		

Part 1: Health Questionnaire (Continued)

Health Questionnaire: Please explain all "Yes" responses below. Circle questions you don't know the answers to.

	Yes	No		Yes	No
21) Do you have any history of juvenile arthritis or connective tissue disease?			22) Do you cough, wheeze, or have difficulty breathing during or after exercise?		
23) Have you ever used an inhaler or taken asthma medicine?			24) Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
25) Do you have groin pain or a painful bulge or hernia in the groin area?			26) Have you had infectious mononucleosis (mono)? (please indicate date on page 3)		
27) Do you have any rashes, pressure sores, or other skin problems?			28) Have you had a herpes or MRSA skin infection?		
29) Have you ever had a head injury or concussion?			30) Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
31) Do you have a history of seizure disorder?			32) Do you have headaches with exercise?		
33) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			34) Have you ever been unable to move your arms or legs after being hit or falling?		
35) Have you ever become ill while exercising in the heat?			36) Do you get frequent muscle cramps when exercising?		
37) Do you or someone in your family have sickle cell trait or disease?			38) Have you had any problems with your eyes or vision?		
39) Have you had any eye injuries?			40) Do you wear glasses or contact lenses?		
41) Do you wear protective eyewear, such as goggles or a face shield?			42) Do you worry about your weight?		
43) Are you trying to or has anyone recommended that you gain or lose weight?			44) Are you on a special diet or do you avoid certain types of foods?		
45) Have you ever had an eating disorder?			46) Do you have any concerns that you would like to discuss with a doctor?		
Questions 45 – 47: FEMALES ONLY			47) Have you ever had a menstrual period?		
48) How old were you when you had your first menstrual period?			49) How many periods have you had in the last 12 months?		

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

____

____

____

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

Signature of athlete: ______________________________ **Date:** ________________

Signature of parent/guardian: __________________________ **Date:** ________________
(If athlete is under 18)

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

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

Healthcare Provider Signature: __________________________ **Date:** ________________

END PART 1

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

Name ______________________________ **Date of Birth:** _______________ **Gender**: _______

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

Note to examining Healthcare Provider: CCSU 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
Height: Weight: BMI: BP: Left: / Right: / Pulse:
Vision Right: 20/ _______ Left: 20/_______OU: 20/_______Corrected? ❑ Y ❑N Peak Flow or attach PFTs (if history of asthma):
MEDICAL (Please note "NE" if area not examined)
General Appearance:
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)?
Eyes/ears/nose/throat:
Lymph nodes:
Heart: (please auscultate sitting, supine, and with squat or 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: _____________

Adapted from *PPE:PREPARTICIPATION PHYSICAL EVALUATION* Fourth Edition ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Editors: David Bernhardt, MD William Roberts, MS CCSU UHS 4/11/12

Connecticut State University Student Health Services Form Instructions

Important: Prior to submitting your information, please make a copy for your records

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.
***VERY IMPORTANT: Please note that if you send this form to your doctor they will only complete sections 1-5 and 7a-7d if applicable. It is your responsibility as an incoming student to complete all other areas of the form prior to submission.

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 lab report 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 lab report 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 lab report 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 lab report results with health form.

Proof of **Meningococcal A,C, W-135 or Y** vaccination (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 moving into the residential halls.

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.

Strongly Recommended

Meningitis B: The Centers for Disease Control recommend students be immunized against **Meno B**.

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**

Tetanus: A booster shot is recommended every ten years – Mandatory for Student Athletes

You may submit any additional vaccinations as a separate attachment should you wish to submit for our record.

Please check your Central Pipeline account no sooner than 3 business days after submitting the required information. Your Central Pipeline account will indicate the MISSING information under the "Registration Status" Section.

Please make a copy for your record. Medical Records are not maintained or transferred with transcripts to other institutions by CCSU.

You may fax to 860-832-2579, Email to sws@ccsu.edu, drop off or mail (Address page 2 of form). All documents sent by email must be sent as a PDF attachment only.

Connecticut State University Student Health Services Form

FOR OFFICE USE ONLY

☐ Complete ☐ Missing: ____________________

Semester 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

Last Name	First Name	MI

Date of Birth and Birthplace:	Sex/Gender:	Student ID #: ☐☐☐☐☐☐☐☐

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

	Vaccine & Date Given OR	Incidence of Disease OR	Titer Test Results (attach lab report)	Requirements
1	Measles #1 ☐ or MMR ☐ Date	Date:	Measles Titer Date :	***Must be*** on or after 1st birthday.
	Measles #2 ☐ or MMR ☐ Date:		Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
2	Mumps #1 ☐ or MMR ☐ Date:	Date	Mumps Titer Date:	***Must be*** on or after 1st birthday.
	Mumps #2 ☐ or MMR ☐ Date:		Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
3	Rubella #1 ☐ or MMR ☐ Date:	Date	Rubella Titer Date:	***Must be*** on or after 1st birthday.
	Rubella #2 ☐ or MMR ☐ Date:		Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
4	Varicella #1 ☐ Date: Varicella #2 ☐ Date: OR	Incidence of Chicken Pox Disease OR Date: Provider Initials:	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**

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

Date(s):1.__________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

Question	Answer
A. Have you ever had a positive tuberculosis skin or blood test in the past? **If you answer, "Yes," Section 7b., "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

Afghanistan,Algeria,Angola,Anguilla,Argentina,Armenia,Azerbaijan,Bahrain,Bangladesh,Belarus,Belize,Benin,Bhutan,Bolivia,Bosnia&Herzegovina,Botswana,Brazil,Brunei,Darussalam,Bulgaria,BurkinaFaso,Burundi,Cambodia,Cameroon,CapeVerde,CentralAfricanRepublic,Chad,China,China:HongKongSpecialAdministrativeRegion,China:MacaoSpecialAdministrativeRegion,Colombia,Comoros,Congo,Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo,Djibouti,DominicanRepublic,Ecuador,ElSalvador,EquatorialGuinea,Eritrea,Estonia,Ethiopia,Fiji,FrenchPolynesia,Gabon,Gambia,Georgia,Ghana,Guam,Guatemala,Guinea,Guinea-Bissau,Guyana,Haiti,Honduras,India,Indonesia,Iraq,Iran,Japan,Kazakhstan,Kenya,Kiribati,Kuwait,Kyrgyzstan,LaoPeople'sDemocratic,Republic,Latvia,Lesotho,Liberia,Libyan,Arab,Jamahiriya,Lithuania,Madagascar,Malawi, Malaysia, Maldives, Mali, Marshall Islands,Mauritania,Mauritius,Mexico,Micronesia(FederatedStates),Mongolia,Morocco,Mozambique,Myanmar(Burma),Namibia,Nauru,Niue,Nepal,Netherlands,Antilles,NewCaledonia, Nicaragua,Niger,Nigeria,NorthernMarianaIslands,Pakistan,Palau,Panama,Papua,NewGuinea,Paraguay,Peru,Philippines,Poland,Portugal,Qatar,Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines, Sao Tome and Principe,Senegal,Serbia,Seychelles,SierraLeone,Singapore,SolomonIslands,Somalia,SouthAfrica,SouthSudan,SriLanka,Sudan,Suriname,Swaziland,Syrian,ArabRepublic,Tajikistan, Taiwan, Thailand, The former Yugoslav Republic of Macedonia,TimorLeste,Togo,Trinidad&Tobago,Turks&Caicos,Tunisia,Turkey,Turkmenistan,Tuvalu,Uganda,Ukraine,United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela(Bolivarian Republic),Viet Nam, Wallis and Futuna Islands, Yemen, Zambia ,Zimbabwe Based on WHO Global TB Report 2013

7. 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.

7a. TB BLOOD TEST	7a. TB SKIN TEST Use 5TU Mantoux test only.		7b. 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 <u>not</u> <u>needed</u> if asymptomatic <u>AND</u> completed full course of treatment for the positive TB test (latent TB).*	7c. TB TREATMENT MEDICATION (with dose):
☐ Interferon-gamma release assay Date:				
Result: ☐ NEG ☐ POS	Date Planted: Date Read:	Interpretation (If no induration, mark 0) ☐ NEG ☐ POS _______mm of induration	**Chest X-ray Date:** Result: ☐ Normal ☐ Abnormal ***(Attach copy of report)***	Frequency: Start & Completion Dates:

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
Last Tetanus Booster: Td ☐ or Tdap ☐ Date:	MENO B	MENO B	MENO B	

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 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.

Signature of Student **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

Student Name	Home/Personal Email Address	Student Cell Phone

Permanent Home Information	Notify in Case of Emergency
Home Phone Cell/Work Phone	Name Relationship
Street Address	Home Phone Cell/Work Phone
City State Zip	Street Address City State Zip
Personal Physician/Healthcare Provider Name:	Address: Telephone #: FAX #

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

☐ **Check here if none apply**

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.**

☐ **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.

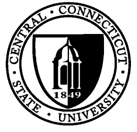
Is there any other medical information or health concern that we should know about? Please attach any additional information to further explain your condition(s) or concern(s).

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

*****not required***

Please make a copy for your records.

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



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 Student Wellness- Health 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 Student Wellness- Health.

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:**
  - **Consult with their parent or guardian**
  - **View NCAA Educational Video https://www.youtube.com/watch?v=EiEpmZLLcuM**
  - **Read NCAA "A Fact Sheet for Student Athlete" http://www.ncaa.org/sites/default/files/NCAASickleCellTraitforSA.pdf**

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

Sincerely,

Dr. Marisol Ostrov, APRN, Ed.D
Associate Director of Student Wellness Services - Health

Kathy Pirog, ATC
Head Athletic Trainer

Central Connecticut State University
Intercollegiate Athletics
Sports Medicine
Sickle Cell Trait Policy

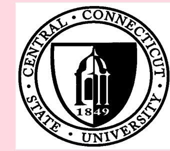
Educational Information

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.



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.

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

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