CCSU STUDENT HEALTH SERVICES

Welcome Varsity Athlete,

As your health and safety are of the utmost importance you must receive medical clearance from our office, **CCSU's Student Health Services at the Student Wellness Center,** 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
4. Upload medical forms and all required documentation to MEDICAT ***at least 2 months prior to your sports anticipated first day of practice and/or preseason conditioning sessions.***

SCAN ME

Your CCSU BlueNet user name and password is needed to login to MEDICAT. A BlueNet account is issued upon acceptance to CCSU as a full-time student.

5. Once all your forms are reviewed and considered complete, an appointment with CCSU Student Health Services for Sport Clearance will be scheduled.

Detailed Instructions for Each of These Steps Are Below: Checklist

Step 1: Connecticut State University Student Health Services' Form (Grey)

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

For help with filling out the forms properly click this link - CHEAT SHEET

Step 2: 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 schedule an appointment with your PCP office as soon as possible and bring this form.

Please note that as per NCAA requirements this exam must be done **within the last 6 months** of the final clearance for your sport by CCSU Student Health Services.

_____ **Pages 1& 2 - Health Questionnaire**

Please complete the health questionnaire 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 3 - Physical Examination**

To be completed by your PCP. Please note that CCSU Health Services 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.

Note: 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 Lab Results for Sickle Cell Trait (SCT)

_____ Please contact your primary care provider to get a copy of your newborn screen test results or request that your PCP order labs for a new sickle cell screening test.
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 or be tested for sickle cell trait. Most states started screening all newborns by 1990.

As of April 2022, the NCAA no longer permits waiving the test results for SCT.

Step 4: SUBMITTING YOUR MEDICAL FORMS and all pertinent health information.

_____ **Upload Medical Forms** into MEDICAT by following the on-screen instructions. Please retain a copy of all forms for your own records.

Your CCSU BlueNet user name and password is needed to login to MEDICAT.

A BlueNet account is issued upon acceptance to CCSU as a full-time student.

IMPORTANT:

1. You can avoid delays in being medically cleared to participate in your sport by completing all necessary medical assessments at home and uploading into MEDICAT ***at least 2 months prior to your sports anticipated first day of practice and/or preseason conditioning sessions***.

2. ***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 your personal medical health forms. It is your responsibility to submit the medical forms directly to CCSU Student Health Services via MEDICAT.

We are very happy you are joining us at Central Connecticut State University. All of us in Student 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.

Amber Cheema, MD
Medical Director
Central Connecticut State University
Student Health Services

Connecticut State University Student Health Services Form

FOR OFFICE USE ONLY

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** ☐ ***OR*** Date: **Varicella #2** ☐ Date:	**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) If living on-campus, your most recent vaccination must be within 5 years of your 1st day of classes at the University. Please note: You will not be permitted to move in to campus housing without first providing the Student Health Service with this information.** Date(s):1._____ 2._____ **Brand of Vaccine:** _____ ☐ **I will not be living on-campus. I do not require this vaccine.**			
6	**TUBERCULOSIS (TB) RISK QUESTIONNAIRE - A through D To be answered by the Student**			

A. Have you ever had a positive tuberculosis skin or blood test in the past? **If you answer, "Yes," Section 6b., "CHEST X-RAY", must be completed**	☐ Yes ☐ No
B. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?	☐ Yes ☐ No
C. Were you born in one of the countries listed below? ***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

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 Date: Result: ☐ NEG ☐ POS	**6a. TB SKIN TEST** **Use 5TU Mantoux test only.** Date Planted: / Date Read:	Interpretation (**If no induration, mark 0**) ☐ NEG ☐ POS _____mm of induration	**6b. CHEST X-RAY** **Required within the past 12 months for a previous or current positive TB skin or blood test.** ***Copy of X-ray report MUST be attached. X-ray is not needed if asymptomatic AND completed full course of treatment for the positive TB test (latent TB).*** **Chest X-ray Date:** Result: ☐ Normal ☐ Abnormal ***(Attach copy of report)***	**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)

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:	Other Vaccination:	Other Vaccination:	Other Vaccination:

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

Page 2

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***

Did you make a copy for your records?

Central Connecticut State
University Student Health Services
1615 Stanley Street
New Britain, CT 06050

CCSU Varsity Athletics: Supplemental Student Health Services

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 - Page 2.
3. Your PCP must then complete *Part 2: The Physical Examination*, attach any necessary information (i.e., Sickle Cell Trait Lab Results), and sign - Page 3.
4. All three pages of this Supplemental PPE form along with the CSU Student Health form ***including any additional information, consult letters, lab and/or radiology reports*** must be uploaded into MEDICAT.

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.

Have you ever been diagnosed with COVID? _____ (Please list date(s) of illness)_____

	Yes	No		Yes	No
1) Do you have any concerns that you would like to discuss with a doctor?			2) Do you have any ongoing medical issues or recent illness?		
3) Have you ever been denied or restricted your participation in sports for a medical reason or injury?			4) Have you ever passed out or nearly passed out DURING or AFTER exercise?		
5) Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			6) Does your heart ever race, flutter, or skip beats (irregular beats) during exercise?		
7) Has a doctor ever told you that you have any heart problems – including myocarditis, or an infection in your heart, or a heart murmur?			8) Has a doctor every requested a test for your heart? For example, ECG, ECHO, stress test.		
9) Do you get light-headed, tired or out of breath more quickly than you would expect given your fitness level?			10) Have you ever had an unexplained seizure?		
11) Has any family member or relative died of heart problems or unexplained death before the age 35, (including drowning or explained car crash)?			12) Does anyone in your family have a genetic heart problem? – such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrythmogenic right ventricular cardiomyopathy, Long or Short- QT, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)		
13) Has anyone in your family had a pacemaker or implanted defibrillator before age 35?			14) Have you ever had a stress fracture, an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
15) Do you have a bone, muscle, or joint injury that bothers you?			16) Do you cough, wheeze, or have difficulty breathing during or after exercise?		

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
17) Have you ever used an inhaler or taken asthma medicine?			18) Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
19) Do you have groin pain or a painful bulge or hernia in the groin area?			20) Do you have any recurring skin rashes or rashes that come and go including herpes, or MRSA?		
21) Have you ever had a concussion or head injury that caused confusion, prolonged headache, or memory problems?			22) Have you ever had numbness, tingling, or weakness in your arms or legs or unable to move your arms or legs after being hit or falling?		
23) Have you ever become ill while exercising in the heat?			24) Do you get frequent muscle cramps when exercising?		
25) Do you or someone in your family have sickle cell trait or disease? Reminder: Per NCAA you must provide **lab results** for of SCT testing with this form.			26) Have you had any problems with your eyes or vision?		
27) Do you worry about your weight?			28) Are you trying to or has anyone recommended that you gain or lose weight?		
29) Are you on a special diet or do you avoid certain types of foods or food groups?			30) Have you ever had an eating disorder?		
31) Have you ever had a menstrual period? **FEMALES only questions 31-34**			32) How old were you when you had your first menstrual period?		
33) How many periods have you had in the last 12 months?			34) When was your most recent menstrual period?		

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

EXAMINATION
Height: Weight: BMI: BP: Left: / Right: / Pulse:
Vision Right: 20/ _____ Left: 20/_____OU: 20/_____Corrected? ❑ Y ❑N Peak Flow or attach PFTs (if history of asthma):
MEDICAL (Please note "NE" if area not examined)
General Appearance:
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)?
Eyes/ears/nose/throat:
Lymph nodes:
Heart: (please auscultate sitting, supine, and with squat or Valsalva) Sitting: Supine: Valsalva/Squat: PMI:
Pulses- include simultaneous femoral and radial pulses:
Lungs:
Abdomen:
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: _____