New Student Athlete Health Forms

Required by New York State

Return by August 1st

Mail:
Concordia College New York
Attn: Student Health Center
171 White Plains Rd
Bronxville, NY 10708
Or scan forms and email to:
Susan.Crane@concordia-ny.edu

IMPORTANT

YOU WILL NOT BE PERMITTED TO ATTEND CLASS OR PARTICIPATE IN YOUR SPORT UNTIL FORMS ARE RETURNED

YOU MUST EITHER WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE ONLINE; INSTRUCTIONS INSIDE

Revised: NOVEMBER 2019

CONCORDIA COLLEGE NEW YORK

INSTRUCTIONS

- All pages of this health packet must be completed and signed.
- Screening for sickle cell trait is MANDATORY for student athletes. A sickle cell screen blood test should be done by your primary care provider. Please include a copy of the lab results for this test. If you have had this test already, repeat testing is not necessary. Please provide lab documentation of the results.
- Your physical must be signed and stamped by your healthcare provider, and immunization records attached.
- Return by August 1st in order to attend class and participate in your sport.

Questions?

Contact the Student Health Services Office
Susan.Crane@concordia-ny.edu
914.337.9300 x2243

SEC. I A

CONCORDIA

_ MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Sport:**_____ **Local Phone:**_____

Date of Birth:_____ **SS#:**_____ **Date:**_____

Address:_____

Allergies & Medications

☐Y ☐N 1) Are you taking any medications? (Prescribed or Over the counter)
If Yes, please list all:_____

☐Y ☐N 2) Do you have any allergies to medications?
If Yes, please list all:_____

☐Y ☐N 3) Do you have any food allergies?
If Yes, please explain:_____

☐Y ☐N 4) Have you ever had a reaction to an insect sting or bite?
If Yes, do you currently carry an Epi-Pen or other injectable epinephrine? ☐Y ☐N

Diseases & Illnesses

Please explain any YES answers in the box provided below

☐Y ☐N 1) Have you ever suffered from any heat related illnesses? (stroke, exhaustion, fainting due to heat)

☐Y ☐N 2) Have you ever fainted for no apparent reason?

☐Y ☐N 3) Have you ever fainted during exercise?

☐Y ☐N 4) Have you ever experienced exertional chest pain or discomfort during exercise?

☐Y ☐N 5) Have you ever been diagnosed with a heart murmur or irregular heart beat?

☐Y ☐N 6) Have you ever experienced racing or skipped heart beats?

☐Y ☐N 7) Do you have a history or low or high blood pressure?

☐Y ☐N 8) Have you ever been diagnosed with asthma?
If Yes, how many times and when do you use it?_____
_____

☐Y ☐N 9) Have you ever experienced a seizure?

☐Y ☐N 10) Have you had surgery of **any** kind before? If YES, please explain:_____

☐Y ☐N 11) Have you ever been diagnosed with ADD/ADHD or any other learning disability?
If Yes, and you are currently taking medication, you must list type of medication on the next line:

Please explain all of your YES answers here: _____

_____

Head & Musculoskeletal Injuries

☐Y ☐N 1) Have you ever been diagnosed with a concussion?
If Yes, how many times? _

☐Y ☐N 2) Have you ever experienced a blow to the head and felt like you had your "bell rung"? For example ringing in the ears or felt dizzy afterwards?
If Yes, how many times? _____

☐Y ☐N 3) Have you ever/do you experience migraines?

☐Y ☐N 4) Do you currently have an undiagnosed injury you would like to be evaluated?
If Yes, please describe: _____

☐Y ☐N 5) Have you ever had a major injury requiring surgery AND/OR extensive rehabilitation?
If Yes, please explain:_____

☐Y ☐N 6) Have you ever been diagnosed with a hernia (any type)?
If Yes, please explain:_____

General Health

☐Y ☐N 1) Are there any food groups which you refuse to eat?
Please List: _____

☐Y ☐N 2) Have you ever been on a diet?

☐Y ☐N 3) Are you happy with your current weight?
If not, how much do you want to weigh?_____

☐Y ☐N 4) Do you feel like you don't know what is healthy to eat and when to eat it?

Mental Health

☐Y ☐N 1) Have you ever been treated for anxiety or depression?

☐Y ☐N 2) If yes, do you currently take medication as part of your treatment? If Yes, please list medications:_____

☐Y ☐N 3) Have you ever been hospitalized for a psychiatric condition? If yes, please explain:_____

_____

Women Only

☐Y ☐N 1) Do you have a regular menstrual cycle?
How many times have you menstruated in the last 6 months? _____12 months? _
When was the first day of your last cycle? _____

☐Y ☐N 2) Have you ever been diagnosed with anemia?
If Yes, are you/have you taken iron pills?_____

☐Y ☐N 3) Do you take a prescribed contraceptive?
Type:_____

Family Health

Please indicate if you or an immediate family member has or had the following:

	Yes	No	Relative (Father, Mother, etc)
Respiratory Disorder (i.e. COPD)	☐	☐	
Kidney Disease	☐	☐	
Heart Attack (list at what age)	☐	☐	
Stroke	☐	☐	
Marfan's Syndrome	☐	☐	
Murmur or Irregular Heartbeat	☐	☐	
High Blood Pressure	☐	☐	
Diabetes Type 1 or 2	☐	☐	
Anemia	☐	☐	
Hemophilia	☐	☐	
Hepatitis A, B, or C	☐	☐	
Sickle Cell Trait	☐	☐	
Mononucleosis (Enlarged spleen?)	☐	☐	
Meningitis (Viral or Bacterial)	☐	☐	
Cancer (Type?)	☐	☐	
Thyroid Disease	☐	☐	
Anaphylactic Shock (allergic shock)	☐	☐	
Migraines	☐	☐	

DO YOU RESIDE IN CAMPUS HOUSING? _____YES _____NO, I'M A COMMUTER

SEC. I B

Department of Athletics & Athletic Training
Pre-Participation Physical Examination Form

Name: _____ Date: _____ Sport: _____

Date of Birth: _____ (Contact) Cell Phone #: _____

Home Address (Include STATE and ZIP): _____

STOP --- BELOW THIS LINE TO BE COMPLETED BY PHYSICIAN ONLY!

Height: _____ Weight: _____ BP: _____ / _____ Pulse: _____

Vision: **R** 20/_____ **L** 20/_____ Glasses or Contacts: **Yes** **No** Pupils: _____

	Normal	**Abnormal**
Head (Concussions, etc.)		
Eyes		
Ears		
Nose		
Lymph Nodes		
Lungs		
Heart		
Abdomen		
Upper Extremities		
Lower Extremities		
Spine/Pelvis		
Skin		
Genitalia		

Has this student-athlete ever been diagnosed with ADD or ADHD? _____
Please list current medications: _____
List all allergies (medications, food, etc): _____
- Type of reaction? (hives, etc): _____

Is this student-athlete allowed to fully participate in athletics without restrictions? (circle) **YES** **NO**
- Please explain if "No": _____

****MANDATORY SICKLE CELL TRAIT SCREEN BLOOD TEST****
THIS IS AN INSTITUTIONAL MANDATE!
You will NOT be allowed to participate without the results of this blood test

ACTUAL LAB RESULTS MUST BE ATTACHED TO THIS FORM

Concordia College has made it their institutional policy that every student-athlete must get tested for this condition.
(Note- this test only needs to be completed ONCE during a student-athlete's collegiate career.)

(Healthcare Provider)_____ (Signature)_____

Date: _____ Phone Number: _____

SEC. II

MANDATORY! MEASLES, MUMPS, RUBELLA VACCINE REQUIREMENTS

Student's Name_____ **Concordia ID C#**_____
Phone Number :(_____) _____ **Date of Birth:** _____
E-mail:_____ **Expected Date of Graduation:** _____

Status: □ 1st year □ Sophomore □ Junior □ Senior □ Transfer Student □ Adult Education Student
□ Graduate student

Health Care Provider (please print) _____
Address: _____
Phone :(____) _____ **Fax :**(_____) _____
Provider's Signature:_____

REQUIRED IMMUNIZATIONS for ALL Students born after 1/01/57

Section A. MMR (Measles, Mumps, Rubella; was not available in the US before 1/1/72)
Month/Day/Year

_____ 1st MMR Dose (Administered after 1st birthday AND after 1/1/1972)
____/____/____

AND

_____ 2nd MMR Dose (Administered after 15 months of age and at least 28 days after 1st dose)
____/____/____

Section B1. Measles
Month/Day/Year

_____ 1st Live Virus Dose (Administered after 1st birthday & 1/1/69)
____/____/____

AND

_____ 2nd Live Virus Dose (Administered after 15 months of age and at least 28 days after 1st dose)
____/____/____

OR

_____ History of Illness (documented by Health Care Provider)

OR

_____ Immunity (Proven by Serologic Testing)
____/____/____

Section B2. Mumps
Month/Day/Year

_____ Live Virus Dose (Administered after 1st birthday & 1/1/69)
____/____/____

OR

_____ History of Illness (documented by Health Care Provider)
____/____/____

OR

_____ Immunity (Proven by Serologic Testing)
____/____/____

Section B3. Rubella (German Measles
Month/Day/Year

_____ Live Virus Dose (Administered after 1st birthday & 1/1/69
____/____/____

OR

_____ Immunity (Proven by Serologic Testing)
____/____/____

Note: History of Illness is NOT acceptable

SEC. III

Meningococcal Meningitis Vaccination Response Form

Meningococcal Vaccine READ CAREFULLY. As per New York State Public Health Law 2167, you MUST either have the vaccine (mandatory for students living on campus) *or* sign a waiver stating you have read about the disease and decline the vaccine.

A. *MANDATORY FOR ALL STUDENTS LIVING ON CAMPUS*
(Circle one) Menimmune /Menactra/Menveo

Meningococcal Meningitis Vaccine (Menactra™, Menomune™, Menveo™,) given within the past 10 years:

Date Given: ____/_____/_____ **Date Given: ____/_____/_____**

Month Day Year **Month Day Year**

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must be provided below.

Name/License#/Office Stamp_____Signature_____

Meningococcal meningitis vaccine (Menactra™/Menomune™ Menveo™*):** Students wishing to ***decline this vaccine must read the information in the box below. **Signing the waiver indicates that you understand the possible risk involved in not receiving this immunization.** If you are under the age of 18, a parent or legal guardian must sign this waiver for you.

Disclosure Statement-Meningococcal Meningitis: College students, especially first-year students living in residence halls, are at a slightly increased risk for contacting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. A vaccine is currently available that will decrease, but not completely eliminate, a person's risk of acquiring meningococcal meningitis. This element of uncertainty remains because there are five (5) different serotypes (A, B, C, Y, & W-135) and the current vaccine does not offer any protection from serotype B. The vaccine, Menactra™/Menomune™, Menveo™ probably protects for 3-5 years, and is extremely safe for use. Menactra™ vaccine is available at the Concordia Student Health Center for a cost. For more specific information about meningococcal meningitis and college student risks, please visit the NYS DOH Web Site at: http://www.health.state.ny.us/nysdoh/immun/meningococcal/index.htm

Please read the information provided above and sign waiver, below.
I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of **not** receiving the vaccine.
I have decided that **I / my child (circle one)** will **not** obtain immunization against meningococcal meningitis disease.

Signature of Student and or Parent/Guardian (If student under 18)

Print Name (clearly) _____ Signature: _____Date: _____

NOTE: IT IS STRONGLY RECOMMENDED THAT A 2ND DOSE OF MENINGITIS VACCINE BE ADMINISTERED TO ALL ADOLESCENTS WHO RECEIVED THE FIRST DOSE PRIOR TO AGE 16.

SEC.IV

YEAR: EMERGENCY CONTACT FORM

Name: _____ Sport(s): _____

Date of Birth: _____ SSN# _____ Sex: _____

Address (List Dorm or Off-Campus Addr): _____
[Include Zip Code if off-campus]

Cell Phone #: _____ Current Year (Fresh/Soph, etc): _____

Primary Care Physician (PCP) Name: _____ PCP Phone #: _____

Please Note: *The Acknowledgement of Insurance Requirements must be read and understood and this form completed **PRIOR** to the student-athlete participating in practice and/or competition.*

Emergency Contact #1:

Name: _____ Relationship to Athlete: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact #2:

Name: _____ Relationship to Athlete: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Father (Guardian) Name: _____

Address (If different from above):

_____

_____

Phone #: _____

Father Employed? Y or N (Please fill out below if yes)

Employer: _____

Employer Address: _____

_____

Phone #: _____

Mother (Guardian) Name:

_____

Address (If different from above):

_____

_____

Phone #:

_____

Mother Employed? Y or N (Please fill out below if yes)

Employer: _____

Employer Address: _____

_____

Phone#: ____

_____

Is the athlete covered by parent/primary insurance? Y or N

Is a referral required? Y or N

***If you will be purchasing health insurance from Concordia, please write your initials & date here: _____**

.

SEC. V

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

OPTION 1: (SIGN BOTH LINES BELOW)
If you are a parent whose child is listed on your insurance policy please initial and date here: _____
OPTION 2: (*SIGN ONLY 2ND LINE BELOW*)
If you are a student-athlete and have purchased your own insurance, please initial and date here: _____

You must initial and date one of the two options above.

NOTE: INTERNATIONAL ATHLETES MUST PURCHASE THE COLLEGE-OFFERED HEALTH INSURNANCE- THIS IS A MANDATORY REQUIREMENT- NO ACCEPTIONS WILL BE MADE.

I, _____, as parent, guardian/legal representative, OR as a student-athlete attest that
(Name, please print)

[my child] [myself] has insurance coverage under a current, in force insurance policy for injuries that occur while they/I are/am participating in intercollegiate athletics. This coverage has limits of at least $25,000.
If there is a material change in coverage or expiration of coverage, I agree to notify Concordia College of this development and update the insurance information I have on file with Concordia College.
I understand and agree that Concordia College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Concordia College.

_____ _____
(Signature of parent, guardian or legal representative) (Date)

_____ _____
(Signature of student-athlete) (Date)

CONSENT FOR MEDICAL TREATMENT & ASSUMPTION OF RISK

I, _____ give consent to the Athletic Training Staff of Concordia College for examination and treatment of myself. I understand that I am involved in intercollegiate athletic activities that could lead to the possibility of injury and need for medical attention. I understand that the Athletic Training Staff at Concordia College will only perform the procedures necessary and within their training to prevent, care for, and rehabilitate athletic injuries. I accept the responsibility to inform the Athletic Training Staff of any injury, illness, an increase of pain, medication, or abnormal responses to treatment and/or rehabilitation. I understand I must report the signs and symptoms of a concussion immediately. When necessary, the athletic training staff may refer me to seek treatment either at the Health Center, or by outside physicians and medical facilities as are available. Consent is further given for admission to a hospital for necessary medical or surgical treatments as ordered by a physician. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable student insurance policy will be paid directly and promptly by the undersigned student and parents or guardians and the College will not be held responsible. **I understand that it is my right to seek physician evaluation and/or rehabilitation services outside of the Athletic Training Staff of Concordia College. In that event, I understand that it is my responsibility to inform the Athletic Training Staff in writing in advance and ensure that the allied healthcare professional that I choose is covered by my personal primary insurance.**

Student's Signature _____ Age _____ Date _____ Parent

or Guardian's Signature _____ Date _____ *(If under*

age 18 and unmarried, parent or guardian must also sign.)

HIPPA CONFIDENTIALITY STATEMENT

HIPPA refers to the Health Insurance Portability and Accountability Act. This act creates national standards to protect individuals' personal health information (PHI) and gives patients increased access to and control over their medical records.

1. **Authorization to release information** – All student-athletes at Concordia must provide permission for disclosures of PHI to non-essential parties involved in the athletics department. The non-essential parties include coaches, administrators, parents, physicians, and other health care workers. Communication with these parties ensures the best quality of care and compliance. The information given to these parties will be the minimal amount needed to conduct these interactions.
2. **Incidental uses and disclosures** – This act explicitly permits certain incidental uses and disclosures that occur as a byproduct of a use or disclosure otherwise permitted by the Privacy Rule. PHI may be overheard by another athlete being treated at the same time, charts being viewed accidentally, and the use of sign-in and appointment sheets for example.

Signature of Student-Athlete:_____ Date:_____

Signature of Parent/Guardian if under 18:_____ Date:_____

WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE

Your bill reflects a charge for the College-offered health insurance. If you are a domestic student and covered by your family's plan or another plan, you may decline the College-offered Health Insurance online at the website below.

IMPORTANT

INTERNATIONAL STUDENTS ARE REQUIRED TO ENROLL IN THE COLLEGE-OFFERED HEALTH INSURANCE

IF YOU HAVE OUT-OF-STATE MEDICAID, PLEASE CONTACT THE STUDENT HEALTH CENTER

www.gallagherstudent.com/concordiany

1. On the top right corner of the screen, click 'Student Login' and log in.
2. On the left toolbar, click 'Student Waive/Enroll'.
3. Choose to waive or enroll. Follow the instructions to complete the form.
4. Print or write down your reference number.
5. If you choose to enroll, you will receive an enrollment packet with instructions for enrolling. The charge on your bill does not indicate enrollment; please follow the instructions in your enrollment packet.

PLEASE ATTACH A COPY OF YOUR VALID HEALTH INSURANCE CARD, FRONT/BACK