WESTERN NEW ENGLAND UNIVERSITY

Admission Health Forms Due: August 1 (Spring Registration, January 3)

DON'T WAIT: SUBMIT YOUR HEALTH FORMS AND COMPLETE YOUR ONLINE HEALTH INSURANCE WAIVER!

A critical next step in becoming a student at Western New England University is making sure you have submitted all necessary health forms and completed your health insurance waiver or enrollment online.
(Important: without the waiver, the charge will remain on your bill)

Who Needs to Complete the Health Forms:

All full-time, incoming students are required to submit health forms. Physical must be current which means within 1 year for students and 6 months for varsity student-athletes from the first day of the start of classes.

Suggestions for Health Form Completion:

Physicals can be performed by appointment at WNE Health Services (even throughout the summer), by your home provider, or urgent care center. Immunization records can be obtained from school, or your provider and additional vaccines may be received from Health Services, your provider, or a pharmacy.

Where to Find the Forms:

The required health forms are included here and online on the Center for Health and Wellness website. The health form outlines the requirements.

Risks of Missed Deadlines:

Without the completed health forms, students *including early arrivals* will not be allowed to move onto campus. Class schedules may also be restricted.

Student-Athletes *MUST* also Complete Athletic Forms:

1. Physicals will not be accepted if they are performed more than 6 months prior to the start of classes (NCAA).
2. Must submit the complete athletic clearance form, signed by your primary care provider with the health form.
3. Must submit sickle cell test results.

Transfer students: We will accept a copy of the physical you provided to your previous school.

Questions or Assistance:

413-782-1211

Send your Completed Health Forms to
Healthservices@wne.edu

SELECT ONE
- ❑ New Student
- ❑ Returning Athlete

Admission Health Form

Must be completed, submitted, and accepted by Health Services

1. This form is for all Western New England full-time students.
2. The physical examination date can be no earlier **than 1 year prior** to the first day of classes and for **athletes no earlier than 6 months** prior (NCAA)

For fall registration return to Health Services *prior to August 1*, for spring registration return *prior to January 3*, or for alternate registration times return within 10 days of notification.

STUDENTS: Please complete this page. Are You: Undergraduate_____ Graduate__ Pharmacy_____ OTD_____ Law_____

_____ I Identify My Gender As M F other_____

Last Name First Middle

Date Of Birth (MM-DD-YY) Cell Phone Home Phone

Home Address City State Zip

Emergency Contact Name Relationship

Cell Phone Work Phone Home Phone

Any Allergies?_____ Prescriptions or over the counter medicines you are taking (include dose)

PERSONAL HISTORY: Please check any that pertain to you. Explain positives in space provided below.

- ☐ Anxiety
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Cancer
- ☐ Chest pain
- ☐ Concussion/Head injury
- ☐ Convulsive disorder
- ☐ Diabetes
- ☐ Ear trouble/Hearing loss
- ☐ Eating disorder
- ☐ Eye trouble/Visual loss
- ☐ Fractures (including stress)
- ☐ Genetic disorder
- ☐ Headaches (recurrent)
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Intestinal/Stomach trouble
- ☐ Joint injury (sprain/dislocation)
- ☐ Kidney disease
- ☐ Mononucleosis
- ☐ Seizures
- ☐ Sicklecelltrait
- ☐ Sinus problems
- ☐ Spleen (Surgical removal)
- ☐ Syncope/Fainting
- ☐ Thyroid disease
- ☐ Tobacco use (e-cigarettes, chewing,)

Other health conditions or surgeries:

_____

FAMILY HISTORY: Please state any serious illness or injuries or if deceased cause.

Father_____ Mother_____ Sibling(s)_____

CONSENT FOR TREATMENT In case of serious illness or accident, I give Western New England University Health Services or its representative(s) permission to secure medical and/or surgical care deemed necessary for my good health. I authorize Health Services to perform medical care and immunizations as deemed necessary by licensed personnel. Also, I have read the Notice of Privacy Practices (HIPAA) disclosing how Western New England University Health Services may use and disclose my protected health information.

Signature_____

Physical Examination/Immunizations

Name_____ Date of Birth:_____

Height_____ Weight_____ BP_____ Pulse_____ Vision R 20/_____ L 20/_____ Corrected Yes/No

	Normal	Abnormal Findings
Appearance (Marfan stigmata)		
Skin		
Eyes, Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal/Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurological, Psychiatric		
Functional mobility		

Is there any reason this student should not participate in sports or rigorous activities? Yes No Specify
Is the patient now under treatment for emotional or psychological conditions? Yes No Specify
Do you have any recommendations regarding the care of this student? Yes No Specify

Western New England University ***requires*** all the following immunizations whether a resident or commuter unless otherwise stated.

Tetanus-Diphtheria Acellular Pertussis *(Tdap/Adacel within 10 yrs.)* Month/Day/Yr.____/____/____

MMR Vaccine #1 *(on or after the first birthday)* Month/Day/Yr.____/____/____
MMR Vaccine #2 *(at least 1 month after the first)* Month/Day/Yr.____/____/____

Hepatitis B Vaccine #1 Month/Day/Yr.____/____/____
Hepatitis B Vaccine #2 *(at least 30 days after the first)* Month/Day/Yr.____/____/____
Hepatitis B Vaccine #3 *(5 months after the second dose)* Month/Day/Yr.____/____/____

Varicella Vaccine #1 *(at or after 12 months of age)* Month/Day/Yr.____/____/____
Varicella Vaccine #2 *(given > 4 weeks after the first dose)* Month/Day/Yr.____/____/____

Meningitis Vaccine MCV4 or MPSV4 Month/Day/Yr.____/____/____
(Required for all students 21 years of age or younger and must be within 5 years of the start of classes) Month/Day/Yr.____/____/____

Meningitis B Vaccine #1 (Bexsero) *(recommended/not required)* Month/Day/Yr.____/____/____
Meningitis B Vaccine #2 *(> 1 month after the first dose)* Month/Day/Yr.____/____/____

COVID-19 Vaccines *(strongly recommended- not required)* Month/Day/Yr.____/____/____
Month/Day/Yr.____/____/____
Month/Day/Yr.____/____/____
Month/Day/Yr.____/____/____

If proof of immunization for measles, mumps, rubella, Hepatitis B or Varicella is not available a blood titer immunity proven by laboratory confirmation will be accepted. **Please attach the laboratory results to this form**.

Print or Stamp

Provider's Name_____ Address_____ Phone_____
Signature_____ MD/DO/NP___ Date of Examination _____

Western New England University Health Services
TUBERCULOSIS (TB) RISK QUESTIONNAIRE

Name _____Date of Birth _____Date_____

1. Have you ever had close contact with persons known or suspected to have active TB disease? ❑ YES ❑ NO
2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If Yes, Please CIRCLE the country below) ❑ YES ❑ NO

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Côte d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries with average incidence rates of ≥ 20 cases per 100,000 population.

3. Have you resided in or traveled to one of more of the countries or territories listed above for a period of one to three months or more? (If yes, CHECK the countries or territories, above) ❑ YES ❑ NO
4. Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long term care facilities, and homeless shelters? ❑ YES ❑ NO
5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ YES ❑ NO
6. Have you ever been a member of any of the following groups that may have an increased incidence of laten M. tuberculosis infection or active TB disease: medically underserved, low income, or abusing drugs or alcohol? ❑ YES ❑ NO

If you answered NO to the above questions, your TB screening is complete. If you answered YES to any of the above questions, please complete one of the following: Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA).

Tuberculin Skin Test (TST):	**Interferon Gamma Release Assay (IGRA)/QuantiFERON Gold**
Date Given: ____/ ___/_____ Date Read: _____/ ____/_____	**Date Obtained: ____/ ___/_____**
Result: _____mm of induration ** Interpretation: positive _____negative____	**Result: positive _____negative____ indeterminate_____**

Name of health care professional (print or type): _____

Address: _____ Phone: _____

Signature: _____ MD/DO/NP/PA

CONSENT TO TREAT MINOR PATIENTS

Massachusetts law requires the consent of a parent/guardian for medical care of persons under 18 years of age. If your dependent is a student at Western New England University, or attending a program at the University, the information below must be completed before treatment can be provided.

I, _____ am the parent/guardian of
(please print)

_____, date of birth_____,
(please print)

who is currently a minor.

I authorize Health and Wellness Services, Western New England University, to provide medical and/or mental health care to my dependent, including but not limited to, diagnostic examinations, medical treatment, and mental health counseling.

I understand that if an injury/illness is determined to be life-threatening, that an ambulance will be called to take my dependent to a hospital and that the provider will make every effort to contact me.

I further understand that once my dependent reaches the age of maturity, my consent for treatment is no longer required.

By my signature, I acknowledge that I have read and understand this consent, and that any questions I have prior to signing this can be answered by calling Health and Wellness Services at (413) 782-1211.

_____ Date: _____
(parent/guardian signature)

PARENT/GUARDIAN EMERGENCY CONTACTS

Name:_____ Phone (day): _____

(evening): _____

Name:_____ Phone (day): _____

(evening): _____

SELECT ONE
New Student
Returning Athlete

Athletic Preparticipation Evaluation

This form MUST be completed by intercollegiate athletes and cannot be done prior to 6 months before 8/28/2023.
This form must be reviewed and signed by your primary care provider. Further documentation may be requested by health services, athletic training, or the team physician.

Name _____Sex _____ Age _____ Date Birth_____Sport/Sports_____

	YES	NO
Have you had a medical illness or injury		
Do you have an ongoing or chronic illness?		
Have you ever been hospitalized overnight?		
Have you ever had surgery?		
Are you currently taking any prescription or over-the-counter medication or using an inhaler?		
Have you ever taken any supplements/vitamins to help you gain or lose weight or improve your performance?		
Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
Have you ever passed out during or after exercise? *		
Have you ever been dizzy during or after exercise? *		
Have you ever had chest pain, pressure, or chest tightness during or after exercise? *		
Do you get tired more quickly than your friends during exercise? *		
Have you ever had racing of your heart or skipped heartbeats? *		
Have you ever had high blood pressure or high cholesterol? *		
Have you ever been told you have a heart murmur? *		
Has any family member or relative died of heart problems or of sudden death before age 50? *		
Have you or your family ever been diagnosed with a genetic heart problem or pacemaker? *		
Have you had a severe viral infection like myocarditis or mononucleosis within the last month? *		
Has a health care provider ever denied or restricted your participation in sports for any heart problems? *		
Has a health care provider ever requested a test for your heart? (EKG/ECHO) *		
Do you have any current skin problems (ex: itching, rashes, acne, warts, fungus, or blisters)?		
Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious, or lost your memory?		
Do you have frequent, prolonged, or severe headaches?		
Have you ever had numbness or tingling in your arms, legs, or feet?		

	YES	NO
Have you ever had a burner, stinger, or pinched nerve?		
Have you ever had a seizure?		
Have you ever become ill from exercising in the heat?		
Do you cough, wheeze or have trouble breathing?		
Do you have asthma?		
Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Do you or does someone in your family have sickle cell trait or disease?		
Do you use any special protective or corrective equipment that for your sport or position (ex: knee brace, special neck roll, foot orthotics, retainer or hearing aid)?		
Have you had any problems with your eyes or vision?		
Have you ever had a sprain, strain or swelling after an injury?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? (If yes check appropriate box and explain below) ❑Head ❑Elbow ❑Hip ❑Neck ❑Forearm ❑Thigh ❑Back ❑Hand ❑Wrist ❑Knee ❑Chest ❑Finger ❑Ankle ❑Foot ❑Shin or calf ❑Upper Arm ❑Shoulder		
Do you want to weigh more or less than you do now?		
Do you regularly lose weight to meet weight requirements for your sport?		
Have you ever had an eating disorder?		
Do you feel stressed or under a lot of pressure?		
Do you ever feel sad, hopeless, depressed, or anxious?		
Have you had COVID 19?		
Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
Menstrual Questions Only		
When was your first menstrual period? When was your most recent menstrual period? How many periods have you had in the last year?		

Explain all "YES" answers here

I hereby state that, to the best of my knowledge, my answers to the questions are complete and correct.
Signature of Athlete (parent/guardian if under 18) _____Date: _____

The remainder of this form is to be completed and *signed* by the licensed health care provider:

After reviewing this health history form with the patient/athlete I have determined that they are
Cleared ❑ Cleared with Recommendations (reason and comments on reverse) ❑ Not cleared ❑
*ECG and referral to cardiologist for any abnormal cardiac history or examination findings or a combination of both.
Name of health care professional (print or type): _____ Date of exam _____
Address: _____ Phone: _____
Signature: _____ MD/DO/NP/PA

Send completed health forms to: Healthservices@wne.edu

Name: _____

SICKLE CELL TRAIT FORM

FOR STUDENTS PARTICIPATING IN AN OFFICIAL NCAA ATHLETIC PROGRAM

- Sickle cell trait is not a disease. Sickle cell trait is an inherited condition affecting the oxygen-carrying substance, hemoglobin, in the red blood cells. You are born with sickle cell trait; it cannot be developed over time or contracted like a disease.
- Sickle cell trait is a common condition (> three million Americans).
- Although Sickle cell trait occurs most commonly in African Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ethnicities may test positive for this condition.
- Those with sickle cell trait usually have no symptoms or any significant health problems. However, sometimes during very intense, sustained physical activity, as can occur with collegiate sports, certain dangerous conditions can develop in those with sickle cell trait, leading to blood vessel and organ (kidneys, muscles, heart) damage that can cause collapse and death. Some of the settings in which this can occur include timed runs, all out exertion of any type for 2 to 3 continuous minutes without a rest period, intense drills, and other bursts of exercise after doing prolonged conditioning training. Extreme heat and dehydration increase the risks. (NCAA: A Fact Sheet for Coaches, Sickle Cell Trait, http://\ veb l.ncaa. org Aveb files/health safety/SickleCellTraitforCoaches.pdf).
- More information and resources regarding sickle cell trait and the NCAA's recommendation for sickle cell trait testing can be found at the NCAA website resource pages regarding the sickle cell trait, accessible at: www.NCAA.org/health-safety.

Sickle Cell Trait Testing

- The NCAA requires all student-athletes have knowledge of their sickle cell trait status. Student-athletes must submit documentation of prior test results; **OR** have a blood test to check for sickle cell trait. Cost of testing is the responsibility of the student. ***This must be completed once before the athlete participates in any intercollegiate athletics event, including strength and conditioning sessions, practices, competitions, etc.***
- Athletes who are positive for the trait will be allowed to participate in intercollegiate athletics; this does NOT prohibit you from playing.

One of the following options must be chosen. Include documentation:

1. Copy of athlete's newborn sickle cell testing result attached. Date: _____
   Most states require testing at birth, check with your hospital or pediatrician.

OR

2. Copy of recent sickle cell screening test result attached. Date: _____
   Cost of testing is the responsibility of the athlete.

Send Completed Health Forms:
Healthservices@wne.edu