# ENROLLMENT PREREQUISITE HEALTH FORM

**This Form must be received by Wellness Services prior to beginning classes and/or moving into the Residence Halls.**
**It is mandatory that all students complete this health form, attach all relevant documentation as directed, and upload it to:**

**Medicat Health Portal** **Portal can be found on our website:** Email: wellness@felician.edu

**https://felician.edu/campus-life/counseling-wellness-services/**

It is **YOUR** responsibility to make sure the health forms and requirements are received by Wellness Services.

**Please read carefully and complete as instructed. PLEASE PRINT:**

## Part I. General Information

Major_____ Entry Date_____

Last Name_____First Name_____Last 4 digits of SSN#_____
**If you are under the age of 18, Parental Consent must be signed by a Parent or a Guardian.** Date of Birth _____/_____/_____

Marital Status: Single_____Married_____ Maiden Name_____ Male_____Female_____

Address_____City_____State_____ZIP_____

Phone_____Alternate Phone_____E-Mail Address_____

**Emergency Contact:** Name_____Phone_____Alternate Phone_____

Address_____City_____State_____ZIP_____

Relationship of Emergency Contact to student_____ Are you a citizen of the United States? Yes_____No_____

Do you have Health Insurance coverage? Yes_____No_____ **If yes, please attach a copy of your insurance card.**

Will you be residing on the Felician University Campus? Yes____No_____

Have you attended Felician University before? Yes_____ No_____If yes, what semester did you last attend class? _____

Under what name did you last attend class? _____

## Part II. History

**Personal History:** List any previous hospitalizations, surgeries, major injuries, and chronic illnesses with dates (mo./yr.)_____

List all current **medications.** Include amount and dosage per day:

List **allergies & reactIons** (medications, environmental, food, other)

**Family History:** If any blood relative has suffered any of the following, please circle the number & indicate which relative.

| | | |
|---|---|---|
| 1. Epilepsy | 6. alcoholism | 11. Tuberculosis |
| 2. Mental Illness | 7. Cancer | 12. Asthma |
| 3. Diabetes | 8. High Blood Pressure | 13. Kidney Disease |
| 4. Heart Disease | 9. Stroke | 14. Hay Fever |
| 5. Sudden Death (before age 55) | 10. Seizures | 15. Marfans Syndrome |

## PART III. Physical Examination

**Required for all students. Must have occurred during the 12 months prior to admission (6 MONTHS FOR ATHLETES)**. Other documentation of a physical exam by a Licensed Care Provider during the 12 months prior is acceptable in lieu of this form.

**Student's Name: (Please Print)** _____ Date: _____

Height: Weight: BMI: BP: Pluse:

Vision: Hearing: _____

| System | **Findings: must be completed by Provider** | |
|---|---|---|
| | **WITHIN NORMAL LIMITS** | **ABNORMAL** |
| 1. General Survey/Psychological | | |
| 2. Integument | | |
| 3. Eyes | | |
| 4. Ears | | |
| 5. Nose/Sinus | | |
| 6. Mouth/Pharynx | | |
| 7. Neck/Thyroid | | |
| 8. Thorax/Lungs | | |
| 9. Breasts | | |
| 10. Heart/PV | | |
| 11. Abdomen | | |
| 12. Hernia | | |
| 13. MS/Motor Function/Extremities | | |
| 14. Spine | | |
| 15. Neurological | | |
| 16. LAB; U/A | | |

Can the student participate in all academic activities? Yes__No__
Explain:_____

Can the student participate in all physical activities? Yes__No__
Explain:_____

Is the student currently under treatment for any medical condition? Yes__No__
Explain:_____

Can the student participate in any clinical/laboratory activities? Yes__No__N/A__
Explain:_____

**Athletes ONLY:**

A. Cleared
B. Cleared after completing evaluation/rehabilitation for:_____
C. Not cleared for: ___Collision ___Contact Non-contact: __Strenuous
__ Moderately Strenuous __ Non-strenuous

Due to:_____

Do you have any general comments or recommendations? _____
_____

List immunizations and/or titers done at time of visit. (record Mantoux test with results on page 3) _____
_____

Licensed Health Care Provider Signature_____Date_____

Printed Name (Provider's Stamp preferred) _____ Phone _____

Address (Office Stamp preferred) _____

Print Name: Last 4 of SSN:

## Part IV. TUBERCULOSIS: MANTOUX (PPD) Tuberculin Skin Test

**Mantoux (PPD) MUST be done no sooner than** 7 days and no longer than 30 days to be considered a **valid test**.

**Required for ALL students. Must have been administered during the 6 months prior to admission.**

***The following information is to be completed by your Licensed Health Care Provider. To be a valid test, the date placed, date read, and size of the reading in millimeters must be documented. (A negative reading would be 0mm.)***

***The test is invalid without signature of Provider, and if read less than 48 hours or more than 72 hours after being placed.***

*Lot#:_____Exp. Date:_____MFR:_____*

*Date Placed:_____Date Read:_____Results:_____*

*Licensed Health Care Provider Signature_____Date: _____*

*Printed Name (Providers Stamp preferred) _____Phone: _____*

*Address (Office Stamp Preferred)_____*

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**In the event of any current or previous positive results (horizontal diameter > 10mm induration), ALL of the following must be submitted.**

1. Copy of positive results documentation.
2. Copy of chest x-ray report. (actual x-ray film not required)
3. Documentation of INH prophylaxis treatment including dates of the treatment.
4. Completed Symptom Assessment for Tuberculosis Form. (available at Wellness Services)

## Part V. Meningococcal (Meningitis) Mandatory University Survey

Required for all students

### This Survey is to be completed by ALL students

Ensure one box is section 1 and one box in section 2 are checked and it is signed and dated.

NOTE: All students residing on campus **MUST** have received the Meningitis vaccine **PRIOR** to moving into residential housing.

### Meningococcal (Meningitis) Mandatory University Survey*

This survey become part of the student's health record and is required by New Jersey State Law, PL 2000c25

Meningococcal Disease is a serious, potentially fatal bacterial illness. Anyone can get Meningococcal Disease but University students, especially those who live in dormitories and teenagers 15-19, have an increased risk of getting Meningococcal Disease. Accordingly, all university students in the State of New Jersey are to be provided information about Meningococcal Disease and available Vaccinations so that in collaboration with their Health Care Provider they may make an informed decision about receiving the Vaccine.

**(check one box in this section)**

### Section 1: Meningitis Information

I have been informed about Meningococcal Disease. I have been informed there is a vaccine available for this disease and informed of the effectiveness of this vaccine against this disease.

I am aware that I can contact the Center for Health at Felician University or my Health Care Provider if I have any questions.

I understand that to be protected against Meningococcal Disease I must receive the vaccine, and until I do, I remain at risk for contracting this disease.

I am in receipt of the Meningococcal Vaccines Information Statement (VIS) that provides information about Meningococcal Disease and vaccines.

☐ Yes ☐ No

**(check one box in this section)**

### Section 2: Meningitis Vaccination

☐ I have already received the Meningitis Vaccine.

☐ I am undecided about whether to receive the Meningitis vaccine.

☐ I have decided to receive the Meningitis Vaccine now or at some future time.

☐ I have decided not to receive the Meningitis Vaccine.

**Student Signature:** **Date:**

Print Name: FELICIAN UNIVERSITY The Franciscan University of New Jersey last 4 of SSN#:

## Part VI. Immunizations and/or Titers Note a 2 Step PPD is required for ALL nursing students. Form can be found on website.

**Attach Proper Documentation for items A thru D to prove immunization or immunity as Required by New Jersey State Law.**

This includes official school immunization records, public health department records, and/or official records signed by a Licensed Health Care Provider. This page 4 may be submitted in lieu of other documents if completed and signed by a Licensed Health Care Provider.
**Exact dates are required.**

**Immunizations:** **Required** for all students.

**Note**: Lab evidence of Blood Titer results showing immunity are acceptable in lieu of documentation of Immunization.

Exemptions allowed by the NJ Department of Health to Immunizations:
1. Medical reasons (must provide written documentation from Primary Care Provider).
2. Religious reasons (must provide written documentation stating objection).

*(Those with medical/religious exemptions may be temporarily excluded from class/activities during threatened or actual disease outbreaks.)*

**A. MMR (MEASLES, MUMPS, RUBELLA) :**

**ALL** students born after 1956 **must** provide **one** of the following:
**Measles** (Rubeola) - 2 doses of live vaccine (1st dose on or after 1st birthday and 2nd dose after 1980) ***OR*** a positive **Rubeola IgG Titer**.
**Mumps** - 1 dose of live vaccine on or after 1st birthday ***OR*** a positive **Mumps IgG Titer**.
**Rubella** (German Measles) - 1 dose of live vaccine on or after 1st birthday ***OR*** a positive **Rubella IgG Titer**.

**B. VARICELLA (Chickenpox)*:***

**ALL** students **must** provide **one** of the following **regardless of age**:
1. Documentation of 2 doses of Varivax®, 4-8 weeks apart.
2. Written statement by Licensed Health Care Provider of having had the disease and what year it occurred.
3. Copies of lab evidence of a positive Varicella Zoster IgG Titer.

**C. HEPATITIS B SERIES:**

**ALL** students **must** provide **one** of the following **regardless of age**:
1. Documentation of 3 doses Hepatitis B Vaccine over a six-month period (0, 1, 6 mos.).
2. Copies of lab evidence of a positive Hepatitis B Surface Antibody Titer.

For students who have not completed all 3 doses of Hepatitis B vaccine, **Provisional Periods** (Temporary Clearances) have been established to do so.

9 months - no vaccine previously received
6 months - 1 documented dose of vaccine received
4 months - 2 documented doses of vaccine received

**E. MENINGOCOCCAL MENINGITIS (MCV4) VACCINE: REQUIRED for students residing on campus.**

If Meningitis vaccine is greater than 5 years ago, a booster is required (NJ Law). If the 1st dose given after the 16th birthday, a booster is not needed.
New Jersey State Law **requires** that all students living in residence halls at four-year institutions of higher education receive the vaccine.
This vaccine is **recommended** for all other students under age 25 and living off campus who want to reduce their risk of meningitis.

**IMMUNIZATIONS**

| | | | |
|---|---|---|---|
| MMR | 1 | 2 | |
| Measles | | | |
| Mumps | | | |
| Rubella | | | |
| Varicella Vaccine | 1 | 2 | |
| Varicella Disease (Date) | | | |
| Hepatitis B | 1 | 2 | 3 |
| Meningococcal MCV4 | | | |
| Tdap | 1 | 2 | |
| Meningitis B | 1 | 2 | 3 |

| | | |
|---|---|---|
| Measles | Date | Titer |
| Mumps | Date | Titer |
| Rubella | Date | Titer |
| Varicella | Date | Titer |
| Hepatitis B Ab Qu | Date | Titer |

**Copies of ACTUAL LAB results must be submitted with this form**. In accordance with New Jersey Department of Health and Senior Services, **equivocal results are treated as negative results and boosters will be required.**

**Licensed Health Care Provider's**

**Signature** _____ **Date** _____
**Provider's Stamp** _____ **Phone** _____
**Address (Office Stamp preferred)** _____

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# ATHLETES ONLY

**Personal Medical History:** Have YOU ever had any of the following medical conditions? Please circle the number

| | | | |
|---|---|---|---|
| 1. High blood pressure | 8. seizure disorder | 15. blood disease/blood clot | 22. eating disorder |
| 2. Any heart disease | 9. thyroid disease | 16. trouble with circulation | 23. stomach ulcer |
| 3. Ruptured organ | 10. skin disease | 17. kidney disease/injury/stones | 24. hernia |
| 4. Hepatitis | 11. diabetes | 18. blood in urine/frequent urinary infections | 25. emotional problems |
| 5. Tuberculosis/coughed up blood | 12. sickle cell anemia or carrier | 19. hearing defect/loss/hearing aid | 26. steroid use |
| 6. Amnesia | 13. anemia | 20. muscular disease | 27. drug dependency |
| 7. Migraine headaches | 14. abnormal bleeding/easy bruising | 21. birth defects | 28. travel sickness |

**Dental History:** Have You ever had any of the following dental conditions? Please answer yes or no in the box (explain "yes" answers)

| | | |
|---|---|---|
| 1. Do you have a dental cap? | 2. Have you ever fractured a tooth? | 3. Do you see a dentist on a regular basis? |
| 4. Have you ever had a tooth knocked out? | 5. Do you wear orthodontic appliances or other dental appliance? | 6. Date of last dental exam |

**Vision History:** Have You ever had any of the following vision conditions? Please answer yes or no in the box (explain "yes" answers)

| | | |
|---|---|---|
| 1. Do you wear glasses? | 2. Do you wear contact lenses? | 3. Do you use protective eye wear for sports? |
| 4. Is your color vision Normal? | 5. Have you ever had an eye injury? | 6. Optometrist or Ophthalmologist:<br>Name<br>Address<br>Phone number |

**Internal:**

Were you born with a complete and functional set of :

Eyes: (yes or no)_____ Kidneys (yes or no)_____

Have you ever had loss of surgery to remove any body organ? (yes or no) _____

If yes, please identify: organ, date, removed, repaired_____

Surgeon:_____ phone:_____

Address:_____

**Cardiac History**: please answer yes or no. If yes, please provide an explanation:

Have you ever felt dizzy, light-headed or passed out during or after exercise?_____

Have you ever had chest pain while exercising?_____

Have you ever had irregular heartbeats or heart palpitations?_____

Have you ever been told you have a heart murmur?_____

Have you ever been seen by a hear specialist? (cardiologist)_____

Have you ever had an echo-cardiogram?_____

Have you ever had a stress (heart) test?_____

*****if yes to any question, copies of all reports are required*****

Cardiologist name_____ phone_____

Address_____

**Respiratory History:** Do you have a history of the following? please answer yes or no.

| | | |
|---|---|---|
| Asthma or exercise induced asthma | Bronchitis or frequent respiratory infections | Pneumonia |
| Nasal congestion | Allergies | Family history of asthma |

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## Athletes only-2

Do you have a croupy or barking cough? Do you cough with exercise or exposure to cold temperatures?_____

Do you have shortness of breath or chest tightness? Do you have shortness of breath with exercise or exposure to cold temperatures?_____

Do you wheeze? Do you wheeze with exercise or exposure to cold temperatures?_____

Have you ever been to an emergency room because of difficulty breathing?_____

Have you ever used an inhaler (puffer) or had a nebulizer treatment?_____

Do you currently use an inhaler (puffer) and/or asthma medications?_____

**For Female Athletes:**
**Women's Health History**- personal or confidential information is not released unless authorized in writing by the student athlete.

Onset of menstrual period? Age at onset_____ regular periods (yes or no)/date of last period_____

Number of days between periods_____ duration of period/number of days_____

Heavy bleeding ever a problem?_____ do you spot or have bleeding between periods?_____

Do you experience any unusual discharge?_____ have you ever had a sexually transmitted disease?_____

Are cramps a frequent problem during your period?_____ do you use a birth control device? Type?_____

Do you do a breast self examination?_____ have you ever had a gynecological exam?_____

Have you ever had a pap smear?_____ are both ovaries complete and functional?_____

Have you had a pregnancy, live birth or abortion?_____ (if yes) number? Date?_____

Gynecologist name_____ phone_____

Address_____

**For Male Athletes:**
**Men's Health History**- personal or confidential information is not released unless authorized in writing by the student athlete.

Have you ever had a genitourinary infection?/sexually transmitted disease?_____

Have you ever had discharge from your penis?_____ do you have a history of testicular torsion?_____

Have you ever had painful urination?_____ are both of your testicles present?_____

Do you perform regular testicular self-exams?_____

**Drug, food supplements and Miscellaneous Agents:** please indicate frequency of use (what type and how frequently?)

| | | | |
|---|---|---|---|
| Vitamins | Iron supplements | Diet pills | Laxatives |
| Antihistamines | Anti-inflammatory | Anabolic steroids | Nutritional supplements (liquid/powder) |
| Caffeine | Alcoholic beverages | Tobacco | Special diet (specify) |

Have you ever had trouble with dehydration?_____

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## Athletes only-3

Have you ever passed out in the heat?_____

Have you ever had heat cramps (due to fluid loss because of excessive heat?)_____

Conditioning status: What have you done to stay in shape?_____

**Orthopedic History:** ***GIVE TRAINER COPIES OF ALL MEDICAL REPORTS FOR ANY ITEMS CHECKED YES***

- Participation may not be allowed without proper documentation. If no documentation is available, please make note N/A

**Have you ever injured or consulted with a physician about any of the following: (write 'yes' in the box if you have)**

### HEAD

| | | |
|---|---|---|
| Unconscious/knocked out/blacked out | Dazed/dizzy | Concussion |
| Fractures | X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) |

### NECK

| | | |
|---|---|---|
| Sprain/strain | Burners/stingers | Disk injury |
| Dislocations/fractures | X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) |

### CHEST WALL

| | |
|---|---|
| Fracture collar bone | Fracture rib, sternum |
| X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) |

### LOWER BACK

| | | |
|---|---|---|
| Sprain/strain | Scoliosis | Disk injury |
| Pain or burning down leg | Weakness or numbness in leg | Pains |
| Fractures | X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) |

### SHOULDERS (indicate right or left)

| | | | | |
|---|---|---|---|---|
| Sprain/strain | A-C separation | Tendonitis/bursitis | Fractures | Dislocations/slips out of place |
| Stringers/burner/dead arm | Pains | Injections | X-rays,CT, MRI (reports required) | Hospitalized/surgery (reports required) |

### ELBOWS (indicate right or left)

| | | |
|---|---|---|
| Sprain/strain | Bursitis/tendonitis | Dislocation/fractures |
| X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) | |

### WRIST (indicate right or left)

| | |
|---|---|
| Sprain/strain | Dislocations/fractures |
| X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) |

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Athletes only-4

**HANDS/FINGERS** (indicate right or left)

| | |
|---|---|
| Sprain/strain | Dislocations/fractures |
| X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) |

**PELVIS/HIPS/GROIN** (indicate right or left)

| | | |
|---|---|---|
| Sprain/strain | Bursitis/tendonitis | Dislocation/fractures |
| X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) | |

**THIGHS** (indicate right or left)

| | | |
|---|---|---|
| Quad/hamstring strain | Calcium deposits in muscle | Fractures |
| X-rays,CT, MRI (reports required) | Hospitalized/surgery (reports required) | |

**KNEES (**indicate right or left)

| | | | |
|---|---|---|---|
| Strain/sprain/torn ligament | Knee cap dislocation/fracture | Chondromalacia | Osgood Schlatter's |
| Bursitis/tendonitis | Swelling/grinding | Locking/giving away | Arthritis |
| Jumper's knee | Wear braces | X-rays, Ct, MRI (reports required) | Hospitalized/surgery (reports required) |

**ANKLES** (indicate right or left)

| | | |
|---|---|---|
| Sprain/strain | Dislocations/fractures | Instability/giving out |
| X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) | |

**FEET/TOES** (indicate right or left)

| | | |
|---|---|---|
| Sprain | Turf toe | Dislocations/fractures |
| X-rays, CT, MRI (reports required) | Hospitalized/surgery (reports required) | Shoe inserts/orthotics |

Do you have any wires, or staples in any part of your body?_____

Orthopedic Surgeon name_____ phone_____
Address_____

Have you ever been evaluated by a Sport Podiatrist/Podiatrist?_____
If yes, please list name, phone number and address_____

**Final Review**: if yes to any question, please explain
Have you had two or do you have now any other medical problems or injuries not listed on this form? _____
_____

Have you been advised to have any surgical procedure?_____

Are there any additional health problems you would prefer to discuss privately with our health provider?_____
Is there any special protective equipment that you require or would like to have provided?_____

Is there any reason that you are not able to participate in athletics?_____

**I hereby certify that the answers to the above questions are true and correct and I authorized the release of the above information to Felician University Sports Medicine staff.**

Signature of athlete_____date_____
Signature of parent or guardian (if athlete is less than 18 years old)_____

## Felician University Sports Medicine-Under 18 Medical Waivers

I, _____, herby authorize and request that medical care be administered to _____, age _____, my son/daughter, by the student health service, hospital and/or any other medical doctor or medical intuition which might render services in the event of injury, illness, or accident while participating in the intercollegiate athletic program representing Felician University. I further request that records of such diagnosis and/or treatment be released to the Felician University Athletic Trainer, head Coach of his/her sport, or its insurance carrier, in order that they will be better informed of his/her medical condition while participating in athletic competition at Felician University. A photostatic copy of this authorization shall be considered as effective and valid as the original.
Signature_____date_____
Home address:_____
Phone number:_____ athlete SS# or Student ID#_____

## Sports Medicine Policies and Procedures

**Athlete**
I have read and understand all the policies and procedures pertaining to Felician University Sports Medicine and agree to ahere to all stipulations of the said program while I am a student athlete at Felician University.

Signature_____ date_____

**Parent/Guardian**
I have read and understand all the policies and procedures pertaining to Felician University Sports Medicine, specifically those pertaining to medical insurance and payment. I agree to adhere to all stipulations of the said program while my child is a student athlete at Felician University.
Signature_____date_____

## Concussion Statement

I understand that it is my responsibility to report all injuries and illnesses, including signs and symptoms of a concussion to my athletic trainer and/or team physician.
I have read and understand the Felician University Concussion Policy. I understand that if I do not follow this policy appropriate disciplinary measures will be taken by the Department of Athletics.
I have read and understand the NCAA Concussion Fact Sheet. After reading the NCAA Concussion fact sheet, I am aware of the following information:

- A concussion is a brain injury, which I am responsible for reporting to my athletic trainer or team physician.
- A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance. You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

If I suspect a teammate has a concussion, I am responsible for reporting the injury to my athletic trainer or team physician.

- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- Following a concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.
- In some cases, repeat concussions can cause permanent brain damage, and even death.

Signature of athlete_____ date_____

Athletes only-6

## Drug Testing Authorization and Substance Abuse Policy

Name_____ sport_____

**Student waiver/consent form**

I have read the Alcohol, Tobacco and other Drug Education and Testing Policy for the Felician University Department of Athletics. I understand the policy, and freely consent to participate in it, undergo all required tests, and cooperate in its administration. Additionally, I understand that the consequences of testing positive for drugs and alcohol are cumulative throughout my career at Felician University. In consideration of participation in the athletics program, I release Felician University from any and all liability and waive any and all claims against the University arising out of the Alcohol, Tobacco and Other Drugs Education and Testing Policy, unless such claim is based on negligent or wrongful conduct of the University.

Participant Signature_____date_____
If under 18, I/We agree (parent/guardian signature)_____

## Sickle Cell Trait Status

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 affecting over 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 an 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. The NCAA mandates that all Division II NCAA student-athletes have knowledge of sick cell trait status MUST be on file in the athletic training room prior to ANY of the above mentioned activities. I understand that the NCAA mandates that I must be tested or provide results of a previous sickle cell test. This legislation, effective as of August 1, 2022 is applicable to all prospective and current student-athletes. I understand that I am NOT cleared to participate in ANY Felician University Athletic events (practice/competition) until I am tested and have provided laboratory results.
For more information on SCT in athletes: http://web1.ncaa.org/web_files/health_safety/SickleCellTraitforSA.pdf

Student-Athlete signature_____date_____

Parent/Guardian signature (if under 18 years of age)_____date_____

## Shared Responsibility for Sports Safety

This document covers you for a period of 30 months from the date of the authorization

Participation in a sport requires an acceptance of risk of injury. Athletes rightfully assume that those who are responsible for the conduct of a sport have taken reasonable precautions to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them.

Periodic analysis of injury patterns lead to refinements in the rules and other safety decisions. However, to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with the rule book is as inefficient as to rely on warning labels to produce compliance with safety guidelines. "Compliance" means respect on everyone's part for the intent and purpose of a rule or guideline.

I have read and understand the Shared Responsibility for Sport Safety Statement.

Signature of Student athlete_____date_____

Signature of parent/guardian (if athlete is less than 18 years old)_____

### Medical Consent

I hereby grant permission to the Felician University Sports Medicine Staff to rend to (son/daughter/self) any treatment or procedure under the scope of the individual's training and education that they deem reasonably necessary to the health and well being of the student athlete. Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

Signature of Student Athlete_____ date_____

Signature of parent/guardian (if athlete is less than 18 years old)_____

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## Medical Information Release Form (HIPAA)

Per the Health Insurance Portability and Accountability Act (HIPAA), the following signature will authorize the athletic director, certified athletic trainers, student sports medicine assistants, team physicians and affiliated medical staff to communicate and view medical records pertaining to health related issues as a result of my participation in the NCAA Athletic Program at Felician University. The following methods of communication and injury documentation can be used:

- Oral, written, or electronic communication regarding health issues between the athletic trainer, the team physician and supporting medical staff
- Oral, written or electronic communication regarding health issues between the athletic trainer, coaching staff and athletic director.
- Oral, written or electronic communication regarding health issues between the Felician University Sports Medicine Department and National Collegiate Athletic Association (NCAA) regarding Meical hardships.
- Oral, written or electronic communication regarding health issues between the athletic trainer and the athlete's parents (per athlete's request)
- Oral written or electronic communication regarding health issues between the athletic trainer, the team physician, supporting medical staff and the Insurance company, Carrier of TOA in which Felician University purchased Secondary Student Basic Accident Medical on my behalf.

I have read and understand the means of communication and documentation that will take place regarding my health history and any injury information that my develop because of my involvement in athletics.

I hereby authorize the release of the above medical information relating to my student athletic injuries as designated above.

Signature_____date_____

I do not wish to release the above medical information and understand that it will be by responsibility to handle all aspects of the communication and payment information for my student athletic related injuries.

Signature_____date_____

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## General Education

To: _____ Date: _____

Thank you for the submission of your Student Health Documents

**FAILURE TO SUBMIT THIS REQUIRED INFORMATION MAY RESULT IN THE WITHOLDING OF FUTURE REGISTRATION AND FINAL GRADES.**

**All information should be uploaded to Medicat Healthcare Portal in *My Felician Hub.*** Please feel free to contact us with any questions you may have regarding your Student Health Record at **201-559-3337.**

☐ Enrollment Prerequisite Health Form. Felician Health Forms can be downloaded from the university website: https://felician.edu/campus-life/wellness-services/

☐ COVID 19 VACCINE and BOOSTER is STRONGLY RECOMMENDED. IT IS REQUIRED FOR ALL OTA AND NURSING STUDENTS.

☐ MENINGOCOCCAL MENINGITIS (MenACWY) VACCINE

***REQUIRED FOR ALL STUDENTS*** New State Requirement as of 6/15/2020

☐ Completed Meningococcal (Meningitis) Mandatory College Survey (page 3 of health form). Ensure one box checked in section 1 and section 2 as well signature and dated on the bottom of the page. ✈ Physical Exam during the past 12 months.

☐ Documentation of negative **PPD** within the past 6 months ***or*** negative **QuantiFERON-TB** Gold ***or*** documentation of positive PPD (in mm) ***with*** copy of chest x-ray report ***and*** any treatment taken or declined ***plus*** a TB Symptoms Assessment Form (available from Wellness Services).

☐ Documentation of #1Measles immunization (given after 1st birthday) ***and*** documentation of #2 Measles immunization after 1980 ***or*** documented immunity through a blood test for **Rubeola Antibody Titer IgG**

☐ Documentation of Mumps immunization (after 1st birthday) ***or*** documented immunity through a blood test for **Mumps Antibody Titer IgG**

☐ Documentation of Rubella immunization (after 1st birthday) ***or*** documented immunity through a blood test for **Rubella Antibody Titer IgG**

☐ Documentation of Varicella (chicken pox) immunizations (2 doses) ***or*** documented immunity by ***either*** a statement from your Licensed Health Care provider of having had the disease ***or*** a blood test for **Varicella Zoster Antibody Titer IgG**

☐ Documentation of Hepatitis B series (3 doses) or documented immunity through blood test for Hepatitis B Surface Antibody Titer

☐ Sickle Cell Lab results- **NEW ATHLETES ONLY**

**Proper documentation is REQUIRED for proof of all immunizations**. This includes official school immunization records, records from any public health department, and/or official records signed by a health care practitioner licensed to practice medicine in the U.S. **Exact dates are required.**

****It is advised you keep a personal copy of all medical records you submit****

**Colleen A. Mulligan-Moran, BSN-RN**
**CAWS: Wellness Services, One Felician Way, Rutherford, NJ 07070**
**(P) 201-559-3337 (F) 201-559-3579**
**Email: wellness@felician.edu**