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 you will be billed for insurance)

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

Where to Find the Forms:
The required health forms are included here and also online at www.wne.edu/healthservices. Please read them carefully and complete the forms or pages that pertain to you. The health form outlines the requirements.

Risks of Missed Deadlines:
Without the completed health forms students will not be allowed to move onto campus and class schedules may be deleted. Students scheduled for early arrival will not be allowed to move onto campus without completed forms.

Student-Athletes 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 the provider with the health form
3. Must submit the sickle cell form

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

Student Health Insurance Waiver or Enrollment Form Due:
September 15 for Fall Registration January 30 for Spring Registration

Student health insurance is mandated by the Commonwealth of Massachusetts and you must submit a waiver or enrollment form every year online. Go to www.gallagherstudent.com/wne, which is available June 15 for fall and December 1 for spring admission

Questions or Assistance:
413-782-1211

Send Completed Forms:
Western New England University Health Services
1215 Wilbraham Road, Springfield MA 01119
Fax: 413-796-2255
Admission Health Form

Must be completed, submitted and accepted by Health Services

1. This form is for freshman, transfer, pre-pharmacy, pharmacy and OTD 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 demographic and health history before going to your health care provider.

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

Other health conditions or surgeries:

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

Father   Brother
Mother   Sister

You must answer the following Tuberculosis risk questions

Were you born in or lived for more than 1 month in any foreign country? Yes No
Have you ever had close contact with anyone sick with TB? Yes No

If you answered YES to either of the TB questions above please print out the TB form and bring it to your physical appointment as you will need a TB skin test or T-SPOT.TB.

Pharmacy (not pre-pharm) must have Tuberculin Skin Test/mantoux) Date read: ______/______/_________ Results: ___________ mm induration

The completion and submission of this form provides consent for treatment (unless otherwise so stipulated in correspondence to Health Services) in case of serious illness or accident, to Western New England University Health Services or its representative(s) to secure medical and/or surgical care deemed necessary for good health. Health Services is authorized to perform medical care as deemed necessary by licensed personnel. The Notice of Privacy Practices (HIPAA) disclosing how Western New England University Health Services may use and disclose my protected health information is available for viewing on the University website under Health Services.
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**  
*(must be within 5 years of the start of classes)*  
Month/Day/Yr ______/_______/___________

**Meningitis B Vaccine #1**(Bexsero)- **not required**  
Month/Day/Yr ______/_______/___________

**Meningitis B Vaccine #2** (> 1 month after the first dose)  
Month/Day/Yr ______/_______/___________

If proof of immunization for a 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 __________________________________ Date of Examination ____________________________

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**Western New England University Health Services** 1215 Willbraham Road, Springfield, MA 01119 • Phone 413-782-1211 • Fax 413-796-2255
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 sudden 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://vebl.ncaa.org/vebl/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 recommends that all student-athletes have knowledge of their sickle cell trait status. Student-athletes must 1) show proof of a prior test with results; 2) have a blood test to check for sickle cell trait; or 3) sign a testing waiver declining options 1 and 2. Whichever option is chosen, it must be completed 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 any documentation if necessary:**

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.

   OR

3. **SICKLE CELL TESTING WAIVER:**

   By signing this waiver I understand and acknowledge that the NCAA recommends that all student-athletes have knowledge of their sickle cell trait status. Additionally, I certify that I have read and fully understand the aforementioned facts and I have had the opportunity to review the NCAA website for further information about sickle cell trait and sickle cell trait testing.

   Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to the Western New England University Athletic Department.

   I do not wish to undergo sickle cell trait testing and I voluntarily agree to release, discharge, indemnify and hold harmless Western New England University, its trustees, employees, agents and their successors and assigns from any and all costs, claims, damages or expenses, including attorney’s fees, arising from any loss or personal injury that might result from my refusal to be tested.

   I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

   **Student-Athlete’s Print Name** _____________________________ Date ________ **Sport/s**________________________

   **Student-Athlete’s Signature** _____________________________

   (Or parent/guardian if athlete under 18)
Athletic Pre-participation Evaluation

This form is to be completed by intercollegiate athletes only and cannot be done prior to 6 months before 8/28. This form must be reviewed and signed by a health care provider.

Name _______________________
Gender __________ Date of Birth______________ Sport/s____________

The remainder of this form is to be completed and signed by the health care provider MD/DO/NP/PA (print or type name) _____________________________________________________________________________
Signature __________________________________________ Date of Evaluation _________/_________/___________

Explain all YES answers and add any pertinent health information not addressed above.
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________

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