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
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
**MEDICAL HISTORY QUESTIONNAIRE**

Name: ___________________________  Sport: ___________________________  Local Phone: ___________________________

Date of Birth: ___________________________  SS#: ___________________________  Date: ___________________________

Address: ___________________________

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**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

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**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: _________________________________________________________________

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**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:

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

DO YOU RESIDE IN CAMPUS HOUSING? _________ YES _________ NO, I'M A COMMUTER
**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: ___________________________
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 ___________________________

Me ni ngococ al me ni ngi t i s y ac ci ne (Me nact ra™/ Me nom un e™ Me nve o™): 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 contracting 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:** ____________________________ **Mother (Guardian) Name:** ____________________________

Address (If different from above):

________________________________________________________________________

Phone #: ____________________________

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

Employer: ____________________________ Employer Address: ____________________________

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 INSURANCE- THIS IS A MANDATORY REQUIREMENT- NO ACCESSIONS WILL BE MADE.

I, ____________________________________________, as parent, guardian/legal representative, OR as a student-athlete attest that

[my child] [myself] has insurance coverage under a current, in force insurance policy for injuries that occur while they/I 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.

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

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