SALVE REGINA UNIVERSITY HEALTH FORM

100 Ochre Point Avenue • Newport, Rhode Island 02840-4129
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COMPLETED FORMS DUE BACK TO THE HEALTH CENTER BY JULY 1.
Failure to submit a completed Health Record will result in the inability to register for classes.
Once your physician has completed and signed pages 3, 4 & 5, the form may be submitted by mail, fax or email.

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Student ID #: _____

Preferred Name: _____ Social Security #: _____ Date of Birth: _____

Sex: ☐M ☐F Place of Birth: _____ How long have you lived in the USA? _____

Entrance Year: _____ Class: ☐FR ☐SO ☐JR ☐SR

Home Phone: _____ Student Cell Phone: _____

Home Address: (Street, City, State, Zip) _____

PERSON TO BE NOTIFIED IN AN EMERGENCY

Name: _____ Relationship: _____

Address: (Street, City, State, Zip) _____

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

INSURANCE INFORMATION

PLEASE ATTACH A COPY OF THE FRONT & BACK OF HEALTH INSURANCE PLAN CARD, PRESCRIPTION PLAN CARD AND AND DENTAL PLAN CARD.
Please provide your son/daughter with a card for your health insurance, prescription plan and dental plan.

Insurance Company Name: _____ Policy #: _____

Claims Address: (Street, City, State, Zip) _____

Subscriber Name: _____

Pre-authorization required? ☐Yes ☐No Phone number for Pre-authorization: _____

Prescription Plan Name and Number: _____

Phone Number for Prescription Authorization: _____

Confidential Medical History Form

Name _____ Date of Birth _____

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs
- ☐ Asthma
- ☐ Heart Disease *(valve, vessel, rheumatic, etc.)*
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pneumonia

Endocrine
- ☐ Adrenal Disorders
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Thyroid Disorder

Kidney
- ☐ Chronic Kidney or Bladder Disease
- ☐ Kidney Stones

Ears/Eyes/Nose/Throat
- ☐ Chronic Sinus Infections
- ☐ Eye Disorders *(other than glasses or contacts)*
- ☐ Hearing Loss
- ☐ Nasal Allergies/Hayfever

Stomach/Bowel
- ☐ Celiac Disease
- ☐ Irritable Bowel Syndrome
- ☐ Stomach/Duodenal Ulcers
- ☐ Ulcerative Colitis/Crohn's
- ☐ Other Liver, Stomach, or Bowel Disease

Neurological
- ☐ Concussions
- ☐ Convulsions/Seizures
- ☐ Migraines/Severe Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Stroke/TIA

Mental Health
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anorexia *(Eating Disorder)*
- ☐ Anxiety Disorder
- ☐ Bulimia *(Eating Disorder)*
- ☐ Depression
- ☐ Drug Dependency
- ☐ Other Mental Health Problems

Hematology/Oncology
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Clots/Clotting Disorders
- ☐ Cancer
- ☐ Radiation Therapy

Orthopedics
- ☐ Arthritis
- ☐ Fractures/Broken Bones

Infectious Diseases
- ☐ Chickenpox/Varicella
- ☐ Hepatitis Type: _____
- ☐ HIV Infection
- ☐ Infectious Mononucleosis
- ☐ Malaria
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Typhoid Fever

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives

STDs
- ☐ Chlamydia
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ HPV
- ☐ Other STD

Surgical History
- ☐ Appendectomy
- ☐ Adenoidectomy
- ☐ Ear Tubes
- ☐ Gallbladder Removal
- ☐ Knee ACL Repair L ___ R ___
- ☐ Knee Arthroscopy L ___ R ___
- ☐ Organ Transplant
- ☐ Ovarian Cyst Removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight Loss Surgery
- ☐ Other Prior Surgeries

_____

Social History
- ☐ Do you drink alcohol?
- ☐ Do you exercise regularly?
- ☐ Do you take recreational drugs?

OB/GYN History
- ☐ Endometriosis
- ☐ Pregnancies #: _____

Exercise History
- ☐ Lack of exercise
- ☐ Exercising regularly

Moderate Exercising
Walking briskly, water aerobics, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

Strenuous Exercising
Running, swimming laps, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

☐ **NO Significant Health Problems**

Remarks_____
_____
_____
_____
_____
_____

Other History
☐ Previous Hospitalizations _____
_____

☐ OTHER Health Problems _____
_____

Does YOUR IMMEDIATE FAMILY have any of the following? ☐ **Adopted (Family history unknown)**

		Mother	Father	Siblings	Grandparents
Alcoholism					
Blood Clots/Clotting Disorders					
Cancer	Breast				
	Colon				
	Melanoma				
	Other Cancers (List Type)				
Diabetes					
Drug Dependency					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Mental Illness					
Stroke					
Sudden Cardiac Arrest (under age 50)					
Other (Please explain)					
Parent Deceased					

PHYSICAL EXAMINATION FOR NON-VARSITY ATHLETES

(Students participating in varsity athletics **MUST** use the Salve Athletics form (page 8).)

Last Name: _____ First Name: _____ DOB: _____

The physical examination must be performed within one year _____.

System	Normal	Abnormal	Explanation of Abnormal Findings
Skin	☐	☐	_____
Ears	☐	☐	_____
Eyes	☐	☐	_____
Nose, throat, teeth	☐	☐	_____
Neck, thyroid	☐	☐	_____
Chest, breasts	☐	☐	_____
Lungs	☐	☐	_____
Heart	☐	☐	_____
Heart murmur	☐	☐	_____
Abdomen, liver, spleen, kidneys	☐	☐	_____
Hernia	☐	☐	_____
Genitalia	☐	☐	_____
Pelvic (if indicated)	☐	☐	_____
Rectal	☐	☐	_____
Lymphatic	☐	☐	_____
Extremities, back, spine	☐	☐	_____
Neurological	☐	☐	_____
Psychological	☐	☐	_____

Ht_____ Wt._____ BP _____ T _____ P_____ R_____

ALLERGIES (please list ALL allergies to medications, foods and other miscellaneous items)

Medications: _____

Food: _____

Other (bees, latex, nuts, seasonal/pollen) _____

MEDICATIONS (include prescriptions, over-the-counter, and herbal)

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Is this patient medically qualified to participate in intramural or club sport activities? ☐ Yes ☐ No

Provider Signature: _____ Date of Examination: _____

Provider Name: _____ Phone: _____ Fax: _____

Address: _____

Due Date
July 1

IMMUNIZATION RECORD

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER
OR YOU CAN SUBMIT A SIGNED IMMUNIZATION RECORD FROM YOUR PRIMARY CARE PROVIDER.

STUDENTS WHO FAIL TO PROVIDE PROOF OF THE REQUIRED IMMUNIZATIONS WILL NOT BE PERMITTED TO REGISTER FOR CLASSES.

Please print student's
Last Name: _____ First Name: _____ Date of Birth: _____

REQUIRED

- **MEASLES, MUMPS, RUBELLA (MMR):** Two doses of MMR are required at least one month apart or positive immune titer verifying immunity.

  MMR Dose 1 ____/_____/____ Dose 2 ____/_____/____ OR Positive Titer ____/_____/____

- **HEPATITIS B:** Three doses (doses one and two given four weeks apart and the third dose should be at least four months after first dose) or positive immune titer verifying immunity.

  Dose 1 ____/_____/____ Dose 2 ____/_____/____ Dose 3 ____/_____/____ OR Positive Titer ____/_____/____

- **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap):** Tdap ____/_____/____ Td ____/_____/____ *
  * Tetanus/diphtheria (Td) booster within the last 10 years.

- **MENINGOCOCCAL VACCINE:** (MCV4) Dose 1 ____/_____/____ Dose 2 * ____/_____/____
  * Required if under 22 years old. If you were vaccinated prior to your 16th birthday, a booster dose (Dose #2) is also required.

- **VARICELLA:** Two doses of chicken pox vaccine are required at least one month apart or positive immune titer verifying immunity or medical provider's documented history of disease.

  Dose 1 ____/_____/____ Dose 2 ____/_____/____ OR Positive titer ____/_____/____ OR Disease History ____/_____/___

- **TUBERCULOSIS: * COMPLETE Tuberculosis (TB) Screening Form** (page 4) **and, if required, TB Risk Assessment** (page 5).

OTHER

- **SEASONAL FLU:** ____/_____/____
- **HEPATITIS A:** Dose 1 ____/_____/____ Dose 2 ____/_____/____
- **HUMAN PAPILLOMAVIRUS VACCINE (HPV):** Dose 1 ____/_____/____ Dose 2 ____/_____/____ Dose 3 ____/_____/____
- **MENINGOCOCCAL SEROGROUP B:*** Dose 1 ____/_____/____ Dose 2 ____/_____/____ Dose 3 ____/_____/____
  * This is not the same as Meningococcal (MCV4)
- **OTHER IMMUNIZATIONS:** _____

_____

_____

_____

- **MEDICAL/RELIGIOUS EXEMPTION:** ☐Yes * Exemption Certificate Required

Health Care Provider: _____ Date: _____

Signature and Title: _____ Office Phone: _____

TUBERCULOSIS (TB) SCREENING FORM

Last Name: _____ First Name: _____ Middle:_____

Home Address: (Street, City, State, Zip) _____

Preferred Name:_____ Social Security #: _____ Date of Birth:_____

Sex: ☐M ☐F Place of Birth:_____

Home Phone: _____ Student Cell Phone: _____

To help us determine if you need to have a TB (Tuberculosis) skin test before coming to Salve Regina University, the following questions must be answered:

1. Are you non-US born, from a high prevalence country, including Africa, Asia, Philippines, Indonesia, Eastern Europe, Latin America, Mexico, Portugal, Caribbean, and the Middle East? ☐ Yes ☐ No
2. Have you lived or had extensive travel to a high prevalence country (listed above)? ☐ Yes ☐ No
3. Have you worked or lived in a potentially high risk setting such as a prison, a long term care facility, a homeless shelter, a residential facility for persons with HIV/AIDS or a drug treatment center? ☐ Yes ☐ No
4. Have you had recent close or prolonged contact with someone with infectious TB? ☐ Yes ☐ No
5. Do you or anyone living in your household have a history of intravenous or other street drug use, or HIV infection/AIDS? ☐ Yes ☐ No
6. Had BCG vaccine? ☐ Yes ☐ No
7. Have you ever had a documented positive TB skin test or history of active TB infection? ☐ Yes ☐ No

If you answered **No** to all of the above questions (1 – 7), no further testing or further action is required. Please sign below, and forward this form with your immunization record to Salve Regina University Health Services.

If you answered **Yes** to any of the first 6 questions and No to question 7, then you are required to have a PPD skin test or TB blood test (IGRA, TB Quantiferon Gold, TB-spot) within 6 months prior to the start of classes. The PPD skin test or IGRA must be performed in the U.S. Please have your provider document the results of your testing below. Sign the form and forward with your immunization record to Salve Regina University Health Services.

If you answered **Yes** to question 7, then you do not need to be retested, but must provide documentation of a negative chest x-ray done in the U.S (within 6 months prior to the start of classes), and documentation of any medication and treatment for your positive TB test. Please attach documentation to this form and forward with your immunization record to Salve Regina University Health Services.

Date TB skin test given: _____ Date TB skin test read (must be read in 48-72 hrs):_____

Results **(must be recorded in mm of induration; if no induration, write "0")**: _____mm

IGRA must be performed in the U.S.: TB Quantiferon Gold _____ TB spot _____ Result: ☐ Positive ☐ Negative ☐ Indeterminate

Chest X-ray (Required if TB skin test is positive): Date: _____ Result: ☐ Normal ☐ Abnormal

Dates of Treatment: _____

Signature of Physician / Medical Provider:_____ Date:_____

Physician / Medical Provider Name: (Please Print) / Clinic Stamp_____

Address_____

Phone number:_____ Fax Number:_____

By signing, I attest that the above information is true to the best of my knowledge.

Student Signature:_____ Date:_____

MEDICAL CARE AUTHORIZATION

"I, the undersigned, hereby specifically authorize Salve Regina University Health Services and/or any authorized member of the staff, or duly affiliated consultant, to provide care in the University Health Services, and for emergency treatment."

IF UNDER 18 YEARS OF AGE, PARENTAL SIGNATURE IS ALSO REQUIRED

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

IF YOU HAVE A SERIOUS MEDICAL CONDITION/DISABILITY, PLEASE COMPLETE

Salve Regina University Health Services would like to notify appropriate departments of your serious medical condition/disability in order to be able to respond to an emergency that might arise as a result of your health problem.

I hereby authorize University Health Services to release information of my serious health problem which is

_____to:

Please check as appropriate:

- ☐ Salve Regina University Emergency Medical Technician/Safety and Security
- ☐ Food Services (food allergies)
- ☐ Counseling

This release is not to be construed as a release of any information other than that specified above, or for any other purpose than that specified above.

This authorization may be terminated by me in writing at any time.

2017 - 2018 PRE-PARTICIPATION MEDICAL REQUIREMENTS
NEW STUDENT-ATHLETES

IF YOU ARE PLANNING ON PLAYING OR TRYING OUT FOR A SALVE REGINA VARSITY SPORT

SCAN THE FOLLOWING 3 COMPLETED DOCUMENTS TO AN IMAGE FILE (e.g. PNG, PDF, JPG) AND UPLOAD THEM TO YOUR SportsWareOnline ACCOUNT (SEE SWOL INSTRUCTIONS):

(all forms can be found on your SporstWareOnline Dashboard or at salveathletics.com/information/sportsmedicine)

1. RECEIVE A PHYSICAL EXAM **PERFORMED AND SIGNED BY A PHYSICIAN** (M.D. or D.O.)

- The exam must be performed within **6 (six) months** of beginning sports participation at Salve.
- Exams performed and signed by other practitioners (e.g. Nurse [RN, NP, FNP]; Physician Assistant [PA, PA-C]) are **NOT** acceptable for first-year varsity student-athletes.
- The exam should follow and be recorded on the:

  Salve Sports Medicine FIRST-YEAR STUDENT-ATHLETE PHYSICAL EXAMINATION FORM

2. SICKLE-CELL TRAIT STATUS VERIFICATION (One of the following)

a) A copy of the result of a sickle cell solubility test. (Strongly recommended)
You may have been tested at birth and may obtain the results from your pediatrician. Alternatively, you can be tested by your PCP or local clinic. The expense of testing is your own but your insurance carrier my cover the cost.

OR **b) You may sign a waiver** releasing Salve Regina University from liability for injuries you may incur due to ignorance of your sickle cell trait status.

3. NCAA BANNED SUBSTANCE EXEMPTION (only if applicable)

(ONLY if you have been prescribed & take a banned substance [e.g. Adderall or Albuterol])
You must have the prescribing medical practitioner complete the *Banned Substance Exemption Form* and attach all supporting documentation.
For more information and a list of banned substances please visit:
www.ncaa.org/health-and-safety/policy/2014-15-ncaa-banned-drugs

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COMPLETE INFORMATION & FORMS VIA THE SPORTSWARE ONLINE ATHLETE DASHBOARD

Logon to SportsWareOnline for the first time:

1. Enter **www.swol123.net** in your web browser.
2. Enter your Salve email address in the "E-Mail" field.
3. Click "Reset Password".
4. Follow the instructions to add a password.
5. Logon to swol123.net and complete all required fields and forms.

Complete all required information in the MY INFO, INSURANCE, & MED HISTORY tabs.

Upload a scan or photograph of BOTH SIDES of your insurance card under the INSURANCE TAB.

Upload your physical exam form, sickle cell trait status or waiver, and NCAA banned substance exemption (if applicable).

KEEP THIS CHECKLIST FOR YOUR RECORDS

First-Year Student-Athlete Physical Examination

A PHYSICIAN (D.O. or M.D.) MUST PERFORM THIS EVALUATION:

- This physical exam is prerequisite for participation in intercollegiate athletics
- The exam must be performed within **6** months of the first date of participation.

Student's Name (PRINT) _____ **DOB** _____
Last, First Middle mm/dd/yyyy

Sports (all expected): _____

PLEASE REVIEW THE FOLLOWING CARDIAC QUESTIONS WITH THE PATIENT.	**Yes**	**No**
1. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
2. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
3. Does your heart ever race or skip beats (irregular beats) during exercise?		
4. Has a doctor ever told you that you have any heart problems? Check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ Kawasaki disease ☐ High cholesterol ☐ A heart infection ☐ Other: _____		
5. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
6. Do you get lightheaded or feel more short of breath than expected during exercise?		
7. Have you ever had an unexplained seizure?		
8. Do you get more tired or short of breath more quickly than your friends during exercise?		
9. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death **before age 50**?		
10. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse: Vision: R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Heart [a]: ・Murmurs (auscultation standing, supine, +/- Valsalva) ・Location of point of maximal impulse (PMI)		
Pulses: Simultaneous femoral and radial pulses		
Eyes/ears/nose/throat: ・Pupils equal ・Hearing		
Lymph nodes		
Lungs		
Abdomen		
Genitourinary (males only) [b]		
Skin: HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Head/Face		
Spine: Neck, Back		
Upper Extremity: Shoulder, Upper Arm, Elbow, Forearm, Wrist, Hand		
Pelvis, Groin, Hips		
Lower Extremity: Thigh, Knee, Lower Leg, Ankle, Foot, Toes		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [b] Consider GU exam if in private setting. Having third party present is recommended.

☐ **Cleared for ALL sports w/out restriction** ☐ **Cleared w/ restrictions and/or follow-up** ☐ **NOT cleared (unfit to participate)**

Explanation:

I have examined the above-named student and completed the pre-participation physical evaluation. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete.

DATE OF EXAM _____ Physician's Signature _____ **,MD or DO**

Name of physician (**print/type**) _____ **,MD or DO**

Office Address _____ Phone _____