healthservices@norwich.edu

DUE NO LATER THAN JULY, 15th, 2025

			Date of Birth:	
First	Middle	Last		Month/Day/Year
Preferred Name:		Gender:	Preferred Pronou	ins:
Lifestyle (Circle <u>ALL</u> that <i>i</i>	Apply): "I Am A… <u>FULL-TIN</u>	ME PART-TIME CIVILIAN	CADET ATHLETE RESIDE	NT COMMUTER "
PERSONAL HEALTH H	ISTORY – <mark>COMPLETED BY S</mark>	TUDENT (AND/OR PARENT	OR LEGAL GUARDIAN IF F	ATIENT UNDER 18)
Medications: List all prescri	ption and over-the-counter	r medicines and supplemen	ts (herbal and nutritional)	you are currently taking:
Do you have allergies? ☐ ☐ Medicines ☐ Polle		specific allergen and describ Stinging Insects	e the reaction:	
Medical History: please list	any relevant medical histor	ry (surgeries, concussions, r	mental health, ADD/ADHD	, diabetes, asthma, etc)
All students are required to between Norwich Universit	•	•		
	=	Commandant.) The sharing		
all medical professionals a	-		• •	
is on campus. This authoriz	ration will expire when the	student either withdraws (or graduates from Norwic	h University.
Student Signature			Date	Signed
Student Signature			Date	Signed
Student Signature Parent/Guardian Signature	e (if student under the age	of 18, please go to next sec		Signed Signed
Parent/Guardian Signature			ction) Date	Signed
Parent/Guardian Signature If patient is under the ag	e of 18, per Vermont Law [Center Health Network req	[1 V.S.A. § 173], Norwich U uires parental/guardianshi	niversity Health Services, p consent to treat. Please	Signed University of Vermont-fill out your information
Parent/Guardian Signature If patient is under the ag	e of 18, per Vermont Law [Center Health Network req	[1 V.S.A. § 173], Norwich U	niversity Health Services, p consent to treat. Please	Signed University of Vermont-fill out your information
Parent/Guardian Signature If patient is under the ag Central Vermont Medical G ar Patient's parent and/or guar	ge of 18, per Vermont Law [Center Health Network req and then check yes or no for ardian, (Print Name)	[1 V.S.A. § 173], Norwich U uires parental/guardianshi each section granting cons	niversity Health Services, p consent to treat. Please ent to treat your student (Relationship)	Signed University of Vermont-fill out your information:
Parent/Guardian Signature If patient is under the ag Central Vermont Medical G ar Patient's parent and/or guar	ge of 18, per Vermont Law [Center Health Network req and then check yes or no for ardian, (Print Name)	[1 V.S.A. § 173], Norwich U uires parental/guardianshi each section granting cons	niversity Health Services, p consent to treat. Please ent to treat your student (Relationship)	Signed University of Vermont-fill out your information:
Parent/Guardian Signature If patient is under the ag Central Vermont Medical G ar Patient's parent and/or guar	ge of 18, per Vermont Law [Center Health Network req and then check yes or no for ardian, (Print Name)	[1 V.S.A. § 173], Norwich U uires parental/guardianshi each section granting cons	niversity Health Services, p consent to treat. Please ent to treat your student (Relationship)	Signed University of Vermont-fill out your information:
Parent/Guardian Signature If patient is under the ag Central Vermont Medical (ar Patient's parent and/or gua permission to treat patient Y N	ge of 18, per Vermont Law [Center Health Network requested then check yes or no for ardian, (Print Name)	[1 V.S.A. § 173], Norwich U uires parental/guardianshi each section granting cons	niversity Health Services, p consent to treat. Please sent to treat your student _ (Relationship)	Signed University of Vermont- fill out your information :, has given
Parent/Guardian Signature If patient is under the ag Central Vermont Medical (ar Patient's parent and/or gua permission to treat patient Y N Scheduling at No Medical Evaluation	ge of 18, per Vermont Law [Center Health Network requested then check yes or no for ardian, (Print Name) through University of Vermous University Health Servich University Health Servich due to symptoms, diagno	[1 V.S.A. § 173], Norwich U uires parental/guardianshi each section granting cons	niversity Health Services, p consent to treat. Please sent to treat your student(Relationship) ment includes: mont Medical Center (non ts and treatment plan (doe	Signed University of Vermont- fill out your information :, has given -emergency)
Parent/Guardian Signature If patient is under the ag Central Vermont Medical (ar Patient's parent and/or gua permission to treat patient Y N Scheduling at No Medical Evaluation include Mental H	ge of 18, per Vermont Law [Center Health Network requested then check yes or no for ardian, (Print Name)	[1 V.S.A. § 173], Norwich U uires parental/guardianshi each section granting cons nont Health Network. Treati vices and UVM/Central Ver	niversity Health Services, p consent to treat. Please sent to treat your student _ (Relationship) ment includes: mont Medical Center (non ts and treatment plan (doe n)	Signed University of Vermont- fill out your information :, has given -emergency)

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FIRST YEAR STUDENT PHYSICAL/PRE-PARTICIPATION EXAMINATION [DUE JULY, 15th, 2025]

- Examination is a prerequisite for participation in NCAA Intercollegiate athletics and NU Corps of Cadets
- Examination must be performed six months of first date of participation (no earlier than February 15th, 2025)

Student's Name (PRIN	NT):			C	Date of Birth:		
·	Last	First	Mid			ay/Year	
VITALS: Ht:	_Wt:BP:	T:P:	R:Visio	n: R 20/ L/20	☐ Male☐Fer	male	
PLEASE REVIEW T	HE FOLLOWING MEI	DICAL QUESTIONS WIT	H PATIENT (R	EQUIRED)		YES	NO
1. Have you ever pas	ssed out or nearly pass	sed out DURING or AFTER	R exercise?	•			
2. Have you ever had	d discomfort, pain, tig	htness, or pressure in you	ur chest during	exercise?			
3. Does your heart e	ever race or skip beats	(irregular beats) during e	exercise?				
4. Has a doctor ever Heart Murmo Other:		e any heart problems? Chisease High Cho	-	pply:			
5. Has a Provider ev	er ordered a test for y	our heart? (ECG/EKG, ech	nocardiogram)				
6. Do you get lighthe	eaded or feel shorter o	of breath than expected o	luring exercise?				
7. Have you ever had	d an unexplained seizu	ıre?					
8. Do you get fatigue	ed or short of breath n	nore quickly than your pe	eers during exer	cise?			
9. Any family history	and/or related death	from cardiovascular dise	ases before the	age of 50?			
ventricular card		trophic cardiomyopathy, syndrome, short QT synd	•		_		
	MEDICAL		NORMAL	Δ.	BNORMAL FINDIN	GS.	
Heart: Murmurs (au		d supine, +/- Valsalva)	INORIVIAL	A	BNORWAL FINDIN	<u>u</u>	
	is femoral and radial p						
	roat: pupils equal and						
Lymph Nodes	Toat. pupils equal allu	Ticaring					
Lungs: (Asthma)							
	or intestinal problems	<u> </u>					
Chest/Breasts	or intestinal problems)					
Genitourinary (male	oc only)						
Skin: diseases	es offiy)						
	e # and severity of con	cussion history)					
Psychological: (beha		cussion mistory)					
r sychological. (Bella	MUSCULOSKELETA	٨١					
Head/Face	IVIOSCOLOSKLLLIA	-15					
Spine							
-	oulder unner arm ell	oow, forearm, wrist, hand	4				
Pelvis, Groin, Hips	iodider, upper arm, en	Jow, Torearm, Wrist, Hand	4				
	igh, knee, lower leg, a	nkle toes					
Lower Extremity.	ilgii, Kilee, lower leg, a	iikie, toes					
		te in intercollegiate athl e /sign the page of unique		·			
Provider Signature:				Date of	Examination:		_
				DO, PA, NP ONL	<u>LY</u>)		
Address:							
Ph:				Fax:			

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<u>LEGAL DOCUMENT</u>: NAME AND DATE OF BIRTH OF PATIENT ARE <u>REQUIRED</u> SIGNATURE OF PROVIDER AND/OR LEGAL STATE CERTIFICATION ARE <u>REQUIRED</u>

Name:

Date of Birth:

First	Midd	le Last	Month/Day/Year
Lifestyle (Circle Of	<mark>NE</mark>): "I Am A <u>FULL-</u>	TIME OR PART-TIME student"	
**	*The following imm	unizations are required by the Ve	ermont Department of Health **
Immunization	Please Circle Type	Dates Given	Vermont State Requirements
TDAP: Tetanus Diphtheria Pertussis	VACCINE	#1/	Must have been administered NO EARLIER THAN AUGUST 1, 2014
MMR: Measles, Mumps, Rubella	VACCINE VACCINE -OR-	#1// #2//	TWO DOSES: Minimum of 4 weeks between doses
	TITER	Positive Titer Date://	MUST ATTACH LAB RESULTS
MCV4: MENINGOCOCCAL (Must be ACWY or Conjugate)	VACCINE VACCINE	Before Age 16// After Age 16//	Mandatory for ALL Residential Students. Must be Meningococcal ACWY or Conjugate to be accepted. Requires Second dose for first-time student under 22 years old & First dose given before 16 years old
VARICELLA: "CHICKENPOX"	VACCINE VACCINE -OR- TITER	#1 / / #2 / / Positive Titer Date: / / _	TWO DOSES: Minimum of four weeks between doses if age 13 or older MUST ATTACH LAB RESULTS
	-OR- HISTORY OF DISEASE		COMPLETE AND ATTACH VERMONT DOCUMENTATION OF VARICELLA DISEASE: (LINK HERE)
HEP B: HEPATITUS B	VACCINE VACCINE VACCINE -OR-	#1 / / #2 / / #3 / /	
	TITER	Positive Titer Date://	MUST ATTACH LAB RESULTS

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Name:			Date of Birth:		
First	Middle	Last		Month/D	ay/Year
	TUBERC	CULOSIS SCREENING RIS	SK FACTORS		
History of a positive TB s	skin test?			YES	NO
Recent close contact wit	th anyone who was sick wit	th TB?		YES	NO
History of cancer, leuker	nia, diabetes, kidney disea	ise, HIV/AIDS, low body w	eight, chronic malabsorption	YES	NO
	lant, IV drug use or use of i				
Resident, employee or v homeless shelter, hospit	rolunteer in a high-risk cong	gregate setting (correctio	nal facility, nursing home,	YES	NO
		h high incidence listed hel	ow for more than six months	YES	NO
_	thin the past 5 years? If yes	_		123	
· -	are defined as areas with	reported or estimated in	cidence of ≥20 cases per		
100,000 population)					
		-	ladesh, Belarus, Belize, Benin,		
	& Herzegovina, Botswana, I		_		
·	-		ombia, Comoros, Congo, Congo		
	'Ivoire, Croatia, Djibouti, D	· · · · · · · · · · · · · · · · · · ·			
	-	_	a, Ghana, Guam, Guatemala,		
			n, Kazakhstan, Kenya, Kiribati,		
I	Kuwait, Kyrgyzstan, Lao PDI		-		
	_	· ·	Marshall Islands, Mauritania,		
		_	zambique, Myanmar, Namibia, ea, Paraguay, Peru, Philippines,		
			& the Grenadines, Sao Tome &		
			nalia, South Africa, Sri Lanka,		
1			Thailand, Timor-Leste, Togo,		
			Jkraine, Uruguay, Uzbekistan,		
	etnam, Yemen, Zambia, Zim	_	oragady, Ozbekistari,		
	above, a TB Skin Test OR In clude testing. Unlike TST, I		e Assay (IGRA) is required. A h prior BCG vaccination.	istory of BCC	3
TST Placed:	TST Rea	ad:	Result:(n	nm of indura	ition)
IGRA Drawn:	Posult /	(CIRCLE ONE), NECATIVE	POSITVE INDETERMINATE BOR		-
-		CIRCLE ONE). NEGATIVE	POSITVE INDETERMINATE BON	DEKLINE	
If positive TST or IGRA, ch	nest x-ray required:				
Date of X-ray:	Result ((CIRCLE ONE): NORMAL A	BNORMAL		
He	ealth care provider signa	ature required only if a	ny questions answered 'yes.	<u>.</u>	
			Date Exam Compl		
Address		City/	State/Zip		
Phone			Fax		
Health Care Provider (S	Signature)		Date Signed		

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Sickle Cell Trait Status Verification

Since August 2022 the NCAA has required that all first-year athletes must verify their Sickle Cell Trait status. What is Sickle Cell Trait?

- 1. https://www.ncaa.org/sports/2016/7/27/sickle-cell-trait.aspx
- 2. https://ncaaorg.s3.amazonaws.com/ssi/other/SSI NCAASickleCellTraitforSA.pdf

Only student-athletes who are new to Norwich Athletics (either first year student, transfer, or first-time playing sport at Norwich) must complete Sickle Cell Trait status confirmation How do I complete this step?:

- 1. Upload a copy of your Sickle Cell Trait Verification or Test Results into the NU Living/StarRez portal. How do I obtain verification of my Sickle Cell Trait Status?
- 1) Obtain and submit a copy of your Newborn Screening Records pertaining to Sickle Cell Trait
 - a) Resources for obtaining your Newborn Screening Records:
 - i) Contact the hospital where you were born and request a copy of sickle cell trait status from your birth. Most states required newborn SCT testing beginning in 1990
 - ii) New England Newborn Screening Program: born in Massachusetts, Rhode Island, Maine, New Hampshire or Vermont
 - (1) Website: https://nensp.umassmed.edu/
 - (2) Email: nbs@umassmed.edu
 (3) Phone: 774-455-4600

OR

- 2) Obtain Sickle Cell Trait Screening results (e.g. Sickle Cell Solubility test or Hemoglobin S test) by getting tested from a physician or other authorized medical provider.
 - (1) This requires a written request from a physician, a blood draw from a physician's office or lab, and a lab test with results indicated. The cost associated with this will be submitted to your insurance plan
 - (a) Quest Diagnostic has a code for the NCAA sickle cell test no referral needed, and results come in 48 hours. Some insurances will cover this, reach out to your insurance provider to determine if this is a cost they will cover.
 - (i) Link for Quest/NCAA https://sicklecelltesting.pwnhealth.com/order

Whichever option is chosen, it must be completed and submitted to NUHS before the athlete participates in any intercollegiate athletics events, 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.