**NORWICH UNIVERSITY HEALTH SERVICES**

**802-485-2552 (P) / 802-485-4577 (F)**

[**healthservices@norwich.edu**](mailto:healthservices@norwich.edu)

**\*\*\*DUE NO LATER THAN JULY 01, 2024\*\*\***

Name: Date of Birth:

First Middle Last Month/Day/Year

Preferred Name: Gender: Preferred Pronouns:

Lifestyle (Circle **ALL** that Apply): “I Am A… **FULL-TIME PART-TIME CIVILIAN CADET ATHLETE RESIDENT COMMUTER** “

**PERSONAL HEALTH HISTORY –COMPLETED BY STUDENT**

|  |
| --- |
| **Medications:** List all prescription and over-the-counter medicines and supplements (herbal and nutritional) you are currently taking: |
| **Do you have allergies**?  No  Yes If yes, identify specific allergen and describe the reaction:  Medicines Pollen Food Stinging Insects |

**Have you ever had any of the following (be sure to comment on any “Yes” responses)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |  | Yes | No |
| Asthma |  |  | Concussion / Head Injury |  |  | Tumor or cancer |  |  |
| Diabetes |  |  | Headaches (severe or chronic) |  |  | Missing Organ |  |  |
| Epilepsy / Seizure Disorder |  |  | Anemia or Other Blood Disorders |  |  | Hernia |  |  |
| Eye Problems |  |  | Hearing Loss |  |  | Eating Disorder |  |  |
| Ear, Nose, Throat Problems |  |  | Fainting spells |  |  | ADD / ADHD |  |  |
| Congenital or Other Heart Problems |  |  | Musculoskeletal Injury |  |  | Depression/Anxiety |  |  |
| Thyroid Disorder |  |  | Sickle Cell Disease |  |  | Skin disease |  |  |
| Recurring kidney or bladder infections |  |  | Paralysis |  |  | Treatment for substance use |  |  |
| Stomach or Intestinal Problems |  |  | Surgery |  |  | COVID-19 |  |  |
| Please provide details and dates for any ‘yes’ answers: | | | | | | | |  |
| ***All students are required to sign below, indicating they are aware that information on these medical forms may be shared between Norwich University Health Services, Norwich University Athletic Trainers and Norwich University Administration (including but not limited to the Dean of Students or Commandant.) The sharing of personal health information is to ensure that all medical professionals are familiar with each student’s health history and help manage any treatment plans while the student is on campus. This authorization will expire when the student either withdraws or graduates from Norwich University.***  **Student Signature Date Signed**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Parent/Guardian Signature (if student under the age of 18) Date Signed** | | | | | | | |  |

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**ANNUAL PHYSICALS OR PRE-PARTICIPATION VISITS MUST BE COMPLETED NO EARLIER THAN FEBRUARY 29, 2024**

Name: Date of Birth:

First Middle Last Month/Day/Year

**HISTORY AND PHYSICAL – COMPLETED AND SIGNED BY HEALTH CARE PROVIDER (MD, DO, PA, NP ONLY)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| B/P: | Pulse: | Height: | Weight: | (Corrected) Vision: L 20/ | R 20/ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Normal | Abnormal |  | Normal | Abnormal |
| Skin |  |  | Peripheral Vascular |  |  |
| HEENT |  |  | Heart Murmur |  |  |
| Lymph Nodes |  |  | Abdomen |  |  |
| Thyroid |  |  | Genitourinary |  |  |
| Chest/Lungs |  |  | Extremities |  |  |
| Breasts |  |  | Reflexes |  |  |
| Cardiovascular |  |  | Neurologic |  |  |
| Please explain any *ABNORMAL* findings: | | | | |  |
| Is this student under treatment for any medical or mental health condition? If yes, please explain the diagnosis and treatment plan: | | | | |  |
| Are there any specific cardiovascular risks or contraindications for this student to participate in either contact or non-contact activities? If so, please describe the limitation and your advice for further evaluation:  Does this student have symptoms or evidence of Hypertrophic Cardiomyopathy or Marfan’s Disease?  Does this student have any family history of Hypertrophic Cardiomyopathy or Marfan’s Disease? | | | | |  |
| **MANDATORY CLEARANCE STATUS**  **(FAILURE TO CHOOSE THE OPTIONS BELOW MAY DELAY PARTICIPATION IN NU ATHLETICS AND CORP OF CADETS)**  This student is: Cleared for all activities without restriction  Not cleared for activities | | | | |  |

**Name of Health Care Provider (Print) Date Exam Completed**

**Address City/State/Zip**

**Phone Fax**

**Health Care Provider (Signature) Date Signed**

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**LEGAL DOCUMENT: NAME AND DATE OF BIRTH OF PATIENT ARE REQUIRED**

**SIGNATURE OF PROVIDER AND/OR LEGAL STATE CERTIFICATION ARE REQUIRED**

Name: Date of Birth:

First Middle Last Month/Day/Year

Lifestyle (Circle **ONE**): “I Am A… **FULL-TIME** OR **PART-TIME** student”

**\*\*The following immunizations are required by the Vermont Department of Health \*\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunization** | **Please Circle Type** | **Dates Given** | **Vermont State Requirements** |
| **TDAP:**  Tetanus  Diphtheria Pertussis  (Must have **ALL**) | VACCINE | #1 \_\_\_ / \_\_\_ / \_\_\_\_\_ | Must have been administered **NO EARLIER THAN AUGUST 1, 2014** |
| **MMR:**  Measles, Mumps, Rubella  (Must have **ALL**) | VACCINE  VACCINE  TITER | #1 \_\_\_ / \_\_\_ / \_\_\_\_\_  #2 \_\_\_ / \_\_\_ / \_\_\_\_\_  Positive Titer Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_ | TWO DOSES: Minimum of 4 weeks between doses  **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  TITER  HISTORY OF DISEASE | #1 \_\_\_ / \_\_\_ / \_\_\_\_\_  #2 \_\_\_ / \_\_\_ / \_\_\_\_\_  Positive Titer Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_ | TWO DOSES: Minimum of four weeks between doses if age 13 or older  **MUST ATTACH LAB RESULTS**  COMPLETE AND ATTACH VERMONT DOCUMENTATION OF VARICELLA DISEASE: ([**LINK HERE**](https://www.healthvermont.gov/sites/default/files/documents/2016/11/ID_IZ_CCP_Documentation_of_Varicella_Disease.pdf)) |
| **HEP B:**  HEPATITUS B | VACCINE  VACCINE  VACCINE  TITER | #1 \_\_\_ / \_\_\_ / \_\_\_\_\_  #2 \_\_\_ / \_\_\_ / \_\_\_\_\_  #3 \_\_\_ / \_\_\_ / \_\_\_\_\_  Positive Titer Date: \_\_\_ / \_\_\_\_ / \_\_\_\_\_ | **MUST ATTACH LAB RESULTS** |

**Name of Health Care Provider (Print)**

**Health Care Provider (Signature) Date Signed**

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**TUBERCULOSIS SCREENING RISK FACTORS**

|  |  |  |
| --- | --- | --- |
| History of a positive TB skin test? | YES | NO |
| Recent close contact with anyone who was sick with TB? | YES | NO |
| History of cancer, leukemia, diabetes, kidney disease, HIV/AIDS, low body weight, chronic malabsorption syndrome, organ transplant, IV drug use or use of immunosuppressive meds such as prednisone? | YES | NO |
| Resident, employee or volunteer in a high-risk congregate setting (correctional facility, nursing home, homeless shelter, hospital)? | YES | NO |
| **Born in or having lived in** one of the countries with high incidence listed below for **more than six months** and arrived in the US within the past 5 years? If yes, circle the country here:  **(“High Incidence” areas are defined as areas with reported or estimated incidence of ≥20 cases per 100,000 population)**  Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, China, Colombia, Comoros, Congo, Congo DR, Cook Islands, Cote d’Ivoire, Croatia, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kuwait, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Macedonia-TFYR, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Micronesia, Moldova-Rep, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Romania, Russian Federation, Rwanda, St. Vincent & the Grenadines, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Syrian Arab Republic, Swaziland, Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Tonga, Trinidad & Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela, Vietnam, Yemen, Zambia, Zimbabwe | YES | NO |

**If ‘yes’ to any questions above, a TB Skin Test OR Interferon-Gamma Release Assay (IGRA) is required. A history of BCG vaccination does not preclude testing. Unlike TST, IGRA is not influenced by prior BCG vaccination.**

**TST Placed: TST Read: Result: (mm of induration)**

**IGRA Drawn: Result (CIRCLE ONE): NEGATIVE POSITVE INDETERMINATE BORDERLINE**

**If positive TST or IGRA, chest x-ray required:**

**Date of X-ray: Result (CIRCLE ONE): NORMAL ABNORMAL**

**Health care provider signature required only if any questions answered ‘yes.’**

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**\*\*Sickle Cell Trait Form Required for NCAA Intercollegiate Athletics\*\***

The NCAA requires that all student-athletes have knowledge of their sickle cell trait status. Student-athletes must

either:

1. Show proof of a prior test with results
   1. Contact the hospital the student was born at and request a copy of the sickle cell trait results (typically done at birth) or,
   2. Contact New England Newborn Screening Program (student must have been born in Maine, Massachusetts, New Hampshire, Rhode Island or Vermont) for a copy of the results. They can be found at <https://nensp.umassmed.edu/>, emailed at [nbs@umassmed.edu](mailto:nbs@umassmed.edu) or called at 774-455-4600 or,
   3. Go to <https://www.cdc.gov/genomics/resources/h.htm> for a list of programs in each state that you can contact for results.
2. Have testing done now
   1. Ask the primary care provider about ordering the Sickle Cell Trait lab test at your local health care office
   2. Go to <https://sicklecelltesting.pwnhealth.com/order> for services provided by Quest Diagnostics

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.***