UNIVERSITY OF SAINT JOSEPH
CONNECTICUT

UNDERGRADUATE STUDENT HEALTH PACKET

Deadlines: Fall: July 15th Spring: December 1st

Enclosed Forms/Documents:	Type of Students Required For:	Comments:
Undergraduate Vaccine Form	All full-time and part-time undergraduate students	Resident students must have the vaccine form on file in order to move into campus housing. Should include a Meningitis (meningococcal) vaccine given within 5 years prior to entry date.
Physical Examination Form	All-full-time undergraduate students	Includes commuters. Examination should be within 12 months prior to entry date. Student athletes must have on file for participation in team activities.
List of Countries/Territories with Increased Tuberculosis Incidence		Reference for health care providers to aid in determining risk factors and need for Tuberculosis testing.
NCAA Medical Exception Documentation Forms	Student athletes who are prescribed the noted medications	This form is required if the student athlete is prescribed medication for ADD/ADHD or is using anabolic steroid preparation for a medical purpose.

TIPS AND INSTRUCTIONS FOR COMPLETING THIS HEALTH PACKET:

Print out and bring all pages to your health care provider. (Non-athletes can omit NCAA Medical Exception Documentation Form).

Allow at least 8 weeks to schedule an appointment with your health care provider.

If you have a clinic at your high school, inquire if you can do your physical and vaccines there.

If you have a new health care provider or are going to urgent care, bring your vaccine list with you.

When sending forms in by mail, please keep a copy for your own records.

SEND FORMS IN TO:

University of Saint Joseph
Health Services
1678 Asylum Avenue
West Hartford, CT 06117

Fax: 860.231.6794 Phone: 860.231.5530

STUDENT HEALTH INSURANCE FEE: Undergraduates with 12 or more credits are charged for the university associated health insurance plan. Students with comparable coverage may opt-out by submitting an annual waiver prior to the published deadline. International students are not permitted to waive unless coverage is U.S. based, provided by the student's sponsoring program and pre-approved by USJ.

Fall semester insurance waiver deadline: September 1st **Spring semester insurance waiver deadline:** February 1st

Entry term:
Year _____

Fall Spring Summer

IMPORTANT: Health Form Deadlines

Fall 7/15 Spring 12/1

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Undergraduate Vaccine Form

Return form to:

USJ Health Services
1678 Asylum Avenue
West Hartford, CT 06117

Fax: 860.231.6794
Phone: 860.231.5530

Name		**Birth date**		**Birth place**	
Address					
Home Phone		**Mobile Phone**		**Email Address**	

Required Vaccines- All Students (For Varicella: vaccines, titer or disease history may be submitted)			
MMR # 1	MMR # 2	( ) Titers attached	
Varicella # 1	Varicella # 2	( ) Titer attached	Date of illness
Titers required only when complete vaccine records not available or for case when date of varicella disease can't be documented. Please administer booster (s) for non-immune results.			
Date of birth exemptions: MMR-born before 1957 Varicella-born in U.S. before 1980.			
Required Vaccine-Resident Students (Meningitis-Meningococcal/MCV4)			
Meningococcal Dose # 1	Meningococcal Dose # 2		
Dose # 2 required if it has been more than 5 years since dose #1 at time of entry.			
Recommended Vaccines- Please discuss vaccines below with the student's primary care provider.			
Serogroup B Meningococcal Dose # 1	Dose # 2	Dose # 3	
Type given:			
Hepatitis B # 1	Hepatitis B # 2	Hepatitis B # 3	
Date tetanus series completed:	Number of doses:	Date Tdap given:	

Risk Based Tuberculosis Testing (Students: Please complete this section before your appointment by answering "yes" or "no" to the following questions.)	
1) Is the student entering the nursing program?	
2) Has the student had close contact with an individual with known or suspected active TB disease?	
3) Has the student had frequent or prolonged visits to countries/territories with high TB prevalence?	
4) Has the student been a resident/employee of high risk congregate setting?	
5) Has the student worked/volunteered in a healthcare setting with clients at increased risk of TB?	
6) Is or has the student been a member of a high risk group with increased incidence of tuberculosis?	

Tuberculosis Testing (Providers: Please perform test if response to any questions above is yes)					
Test performed:	IGRA	Chest x-ray	PPD	Results:	Date resulted:
Testing should be within one year of entry. Chest x-ray required for (+) PPD or IGRA. Please attach results.					
Prophylactic treatment prescribed:	Yes	No	If completed, please attach treatment information.		

Entry term:
Year _____

Fall Spring Summer

IMPORTANT: Health Form Deadlines

Fall 7/15 **Spring 12/1**

UNIVERSITY OF SAINT JOSEPH
CONNECTICUT

Undergraduate Physical Examination Form

Return form to:

USJ Health Services
1678 Asylum Avenue
West Hartford, CT 06117

Fax: 860.231.6794
Phone: 860.231.5530

Student name: _____ USJ ID: _____

Student athletes, please record sport (s) here: _____

So that Health Services can better assist with your health needs, you may record any important details here:

_____

_____

HEALTH CARE PROVIDER SECTION:

Allergies: None Medications Food Animal Environmental Other

Please list: _____ **Epi-Pen prescribed:** Yes No

PHYSICAL EXAMINATION (MUST BE WITHIN ONE YEAR OF STUDENT'S ENTRY TO USJ)

Height _____ Weight _____ B/P _____ Pulse _____

Vision Screen os _____ od _____ ou _____ corrected uncorrected

System	Findings	System	Findings
HEENT		Abdomen	
Neck/Thyroid/Lymphatics		Musculoskeletal	
Cardiac		Neurological	
Lungs		Skin	

COMPLETE THIS SECTION FOR STUDENT ATHLETES:

Does the athlete have: Marfan's Disease Absence of paired organ History of concussions

Please provided details (as applies) for items listed above: _____

_____

Does the athlete have: Sickle Cell Trait Sickle Cell Disease *If related laboratory testing is available, please attach.*

Does the athlete take medication for ADD/ADHD or anabolic steroid for medical purpose?: Yes No

Provider please complete and return the applicable medical exception form available in this packet.

MD/DO/APRN/PAC name: _____ Signature: _____

Phone: _____ Fax: _____ Date of exam: _____

IMPORTANT: Please be sure to submit the prior page showing vaccinations and Tuberculosis testing.

University of Saint Joseph Health Services

Countries/Territories with Increased Tuberculosis Incidence

Reference for Risk Based Tuberculosis Testing

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

This information was accessed from the American College Health Association web page on 12/7/18.

https://www.acha.org/

https://www.acha.org/ACHA/Resources/Guidelines/ACHA/Resources/Guidelines.aspx?hkey=450d50ec-a623-47a2-aab0-5f011ca437fb

Providers: Please fill out this form if the athlete is taking stimulant medication as treatment for ADD/ADHD.

NCAA Medical Exception Documentation Reporting Form
to Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and
Treatment with Banned Stimulant Medication

•Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.

•Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (see Medical Exceptions Procedures atwww.ncaa.org/drugtesting).

To be completed by the Institution:

Institution Name: _____

Institutional Representative Submitting Form:

Name: _____

Title: _____

Email: _____

Phone: _____

Student-Athlete Name: _____

Student-Athlete Date of Birth: _____

Prescribed banned medication: _____

To be completed by the Student-Athlete's Physician:

Current Treating Physician (print name): _____

Specialty: _____

Office address:_____

Physician signature: _____

Date: _____

Providers: Please fill out this form if the athlete is taking stimulant medication as treatment for ADD/ADHD.

NCAA Medical Exception Documentation Reporting Form
to Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and Treatment with Banned Stimulant Medication

Check off that documentation representing each of the items below is attached to this report:

- ❑Diagnosis.
- ❑Medication(s) and dosage.
- ❑Has considered a non-banned medication alternative.
- ❑Blood pressure and pulse readings and comments.
- ❑Follow-up orders.
- ❑Date of clinical evaluation: _____
- ❑Attach written report summary of comprehensive clinical evaluation.

Please note that this includes the original clinical notes of the diagnostic evaluation. The evaluation should include individual and family history, address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation, such as completed ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores. The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

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Providers: Please fill out this form if the athlete is taking: Anabolic agents, Anti-Estrogens or Peptide Hormones

NCAA Medical Exception Documentation Reporting Form
Pre-approval for Treatment with Anabolic Agents, Anti-estrogens or Peptide Hormones

NCAA Medical Exception Procedures require that the use of an ***anabolic agent, anti-estrogen or peptide hormone must be approved by the NCAA before the student-athlete is allowed to participate in competition while taking these medications**. To submit for a medical exception for these substances:

•Complete this form.
•Attached medical documentation supporting the diagnosis and treatment (see Medical Exceptions Procedures at www.ncaa.org/drugtesting).
•Submit form and medical documentation to ssi@ncaa.org, prior to student-athlete competing while using these banned drugs.

To be completed by the Institution:

Institution Name:_____

Institutional Representative Submitting Form:

Name_____

Title_____

Email_____

Phone_____

Student-Athlete Name_____

Student-Athlete Date of Birth_____

Medication for which the approval is requested_____

To be completed by the Student-Athlete's Physician:

Current Treating Physician (print name):_____

Specialty:_____

Office address_____

Physician signature:_____ Date_____

Check off that documentation representing each of the items below is attached to this report:

❑Diagnostic evaluation, include any laboratory work supporting the diagnosis.
❑Treatment history.
❑Medication(s) and dosage.
❑Follow-up orders.

NCAA July 2018