Health

REQUIRED

Report

PRINT

Wells College

• **Mail** *to the Community Medical Center at* **18 Wells Road, Aurora, NY 13026**

• **Fax** *the form to the Community Medical Center at* **(315) 364-7287**

Last Name _____ First Name _____ Middle Name _____

Date _____ College ID # _____ Social Security # _____

Address _____ Home Phone _____

City, State, Zip _____ Cell Number _____

Birthplace _____ U.S. Citizenship ◯ Yes ◯ No Sex ◯ M ◯ F Age ____ Date of Birth _____

Emergency Contact & Relationship _____ Phone # _____

Emergency Contact & Relationship _____ Phone # _____

Insurance _____ I.D. # _____ Group # _____

Please send a copy of the front and back of the insurance card with this physical form.

To comply with New York State regulations and to assist us in providing quality medical care for our students, **Wells College requires each new student to undergo a complete medical examination prior to enrolling at the College.** Forms should be returned to the Community Medical Center once completed by your physician. All forms must be returned prior to your arrival for New Student Orientation.

In addition, certification of immunization for measles, mumps and rubella, and administration of the basic services of DPT (diptheria and tetanus toxoids, and pertussis vaccine) and a DT booster must be received prior to registration of classes. New York State requires immunization against measles, mumps and rubella for college students.

You may not be permitted to register for courses without having a physician's completed medical evaluation on file in the Community Medical Center. Therefore, you are encouraged to make arrangements for your examination in advance of your arrival on campus. If necessary, you can be examined once you arrive at Wells for a $150 fee, plus an additional charge for immunizations if they are not up-to-date.

STUDENT AUTHORIZATION SECTION (PARENTS PLEASE SIGN BELOW IF STUDENT IS UNDER 18)

To the parents of entering students:

While your daughter or son is a student at Wells, we request your permission to give medical service should the need arise. Your signature on the consent form below, properly witnessed, will authorize us to proceed with the care of standard medical problems. Of course, should any major health problem occur, we will notify you as promptly as possible and be guided by your wishes for care. Because many students enter with pre-existing conditions that have been treated by physicians knowledgeable about their histories, we further request permission for the release of medical records and prescriptions as appropriate.

Wells College Community Medical Center Consent Form

I do hereby authorize the performance of medical examinations and the use or administration of such diagnostic tests and X-rays, drugs, immunizations and other treatments including minor surgical procedures such as incision of superficial abscesses or boils, suturing of lacerations, and non-operative reduction and immobilization of fractures and dislocations, but excluding major surgical procedures, as may be deemed advisable or necessary by any physician who is a consultant to the Community Medical Center, for or upon the student who is named below. The consent shall be in effect for the period during which my daughter or son is enrolled as a student at Wells College.

I hereby authorize Dr. _____ to give the Community Medical Center access to all materials that pertain to treatment my daughter or son has received, including medical history, lab reports, X-rays, EKG and medications prescribed.

NAME OF STUDENT	RELATIONSHIP TO STUDENT
WITNESS	STUDENT SIGNATURE/PARENT OR GUARDIAN IF 18 OR UNDER
DATE	DATE

Home Physician

NAME _____ PHONE NUMBER (_____) _____

ADDRESS _____

_____

_____

FAMILY HISTORY (IF KNOWN)

RELATIONSHIP	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brother(s)					
Sister(s)					
Children					
Have any of your family or blood relatives ever had any of the following illnesses? Please give relationship.					
Asthma					
Cancer (type)					
Diabetes					
Heart Disease					
Tuberculosis					
Stomach Disease					
Sickle Cell disease/trait					
Kidney Disease					
Hay Fever					
Arthritis					
High Blood Pressure					
Depression/Anxiety					
Bipolar/ADHD					
Any chronic illness not mentioned		Sudden Death before age 50			
Other (specify)					

PERSONAL HISTORY

History of injuries and/or operations: (Give nature & year)

How often do you exercise? ◯ Daily 30-60 min ◯ 3 times Weekly 30-60 min. ◯ Other _____

Have you ever been diagnosed with depression/anxiety/ or other psychological illness? (Please explain) _____

Are you using any medication/supplement with or without a prescription? Please explain and state drug name.

Have you had (please check if they apply to you):

- ☐ Diabetes
- ☐ Anxiety
- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Dizziness/Fainting
- ☐ Gain/Loss of Weight
- ☐ Frequent Urination
- ☐ Chronic Cough
- ☐ Sugar in Urine
- ☐ Insomnia
- ☐ Heart Murmur/Palpitations
- ☐ Sinusitis
- ☐ Excessive Menstrual Flow (Irregular Periods)
- ☐ Arrhythmia
- ☐ Disease/Injury Joints
- ☐ Eye Trouble
- ☐ Head Injury/Concussion
- ☐ Tumor/Cancer/Cyst
- ☐ Venereal Disease
- ☐ Severe Cramps
- ☐ Broken Bones/Stress Fracture
- ☐ German Measles
- ☐ Convulsions/Seizures
- ☐ Depression
- ☐ Stomach/Intestine trouble
- ☐ Blood in Urine
- ☐ Hay Fever/Asthma
- ☐ Gum/Tooth Disease
- ☐ Back Problems
- ☐ Ears/Nose/Throat Trouble
- ☐ Chest Pain/Pressure
- ☐ Recurrent Diarrhea
- ☐ Seizures
- ☐ Dislocations
- ☐ Measles
- ☐ Single Organ (kidney, testicle, eye)
- ☐ Abnormal bleeding/bruising
- ☐ Undescended Testicle
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Mononucleosis
- ☐ Herpes
- ☐ Hepatitis/Jaundice
- ☐ Anemia
- ☐ Weakness/Paralysis
- ☐ Sickle Cell Disease/Trait
- ☐ Scoliosis
- ☐ Recurrent Headaches
- ☐ Hearing impairment
- ☐ Recurrent Skin infections

Have you ever had any surgery? Describe _____

Have you ever had heat stroke or heat exhaustion? _____

List Allergies: _____

List Medications: _____

Has your physical activity been restricted during the past five years? ◯ Yes ◯ No

Give reasons and durations: _____

Have you received treatment or counseling for an emotional/social disorder, personality/character disorder, or eating problem? ◯ Yes ◯ No

Have you had any illness or injury or been hospitalized other than already noted? ◯ Yes ◯ No

Give details: _____

IMMUNIZATIONS

Last year of high school attendance: _____

Attendance at Wells College is contingent on verification of immunization requirements. New York State Public Health Law 2165 requires post-secondary students to show protection against measles, mumps and rubella. Persons born prior to January 1, 1957 are exempt from this requirement. As of August 1, 2019 the Community Medical Center will require full immunization records to be attached to the Wells College Health Report.

TO BE COMPLETED BY MEDICAL PROVIDER

REQUIRED: Measles (Rubeola) Immunity Must have one of the following:

Must have one of the following:

1. **Two dates** of measles immunization. **Both** must be given after 1967 **and** on or after the first birthday.
   First Date: _____ Second Date: _____
2. Date of Measles Titer†: _____ **Please attach results to this Health Report**
3. Date of physician-diagnosed measles disease: _____
   and Signature of Diagnosing Physician: _____

REQUIRED: Rubella (German Measles) Immunity Must have one of the following:

1. Date of **at least one** rubella immunization. **Must** be on or after the first birthday.
   First Date: _____ Second Date: _____
2. Date of Rubella Titer†: _____ **Please attach results to this Health Report**
   Physician diagnosis is not acceptable.

REQUIRED: Mumps Immunity Must have one of the following:

1. Date of **at least one** mumps immunization. **Must** be on or after the first birthday.
   First Date: _____ Second Date: _____
2. Date of Mumps Titer†: _____ **Please attach results to this Health Report**
3. Date of physician-diagnosed mumps disease: _____
   and Signature of Diagnosing Physician: _____

ADDITIONAL VACCINES & TESTING (Recommended)

Tetanus (Td) Booster Date: _____ (should be given every 10 years)

Tuberculin Skin Test (PPD) Test Date: _____ Results: _____

Hepatitis B Vaccine: Date 1: _____ Date 2: _____ Date 3: _____

Signature of Provider: _____

ADDITIONAL VACCINES & TESTING (Recommended) (continued)

MENINGOCOCCAL MENINGITIS VACCINATION (PLEASE SIGN BELOW)

This information **MUST** be completed.

New York State Public Health Law requires that all college and university students enrolled for at least six semester hours or the equivalent per semester, or at least four semester hours per quarter, complete and return this information.

CHECK ONE BOX AND SIGN BELOW.

☐ I have had meningococcal immunization within the past 5 years. *[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College students should discuss the Meningococcal B vaccine with a healthcare provider.]*

☐ 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) will not obtain immunization against meningococcal meningitis disease.

☐ **IMMUNIZATION EXEMPTION** ☐ Medical ☐ Religious ☐ Age
If medical or religious exemptions apply the student must have documentation from their doctor as well as a notarized statement by the patient or parent/guardian if 18 years old and younger. To request an Immunization Letter for an Immunization Exemption, contact the Dean of Student's office at 315.364.3311.

_____ _____

PRINTED NAME OF STUDENT/PARENT OR GUARDIAN IF 18 OR UNDER | STUDENT'S DATE OF BIRTH | DATE

_____

STUDENT SIGNATURE/PARENT OR GUARDIAN IF 18 OR UNDER

PHYSICAL EVALUATION *(to be completed by the physician)* Please review the student's health report and complete the physical form.

Name: (Last, First, MI)_____

Are there any irregularities of the following systems?

	NO	YES	Use this area to describe fully any positive findings and clarify recommendations:
Head/Neck	☐	☐	_____
Ears/Nose/Throat	☐	☐	_____
Eyes	☐	☐	_____
Teeth	☐	☐	_____
Thyroid	☐	☐	_____
Heart	☐	☐	_____
Lungs	☐	☐	
Breasts	☐	☐	_____
Back	☐	☐	_____
Abdomen	☐	☐	_____
Genito-Urinary	☐	☐	_____
Extremities	☐	☐	_____
Skin	☐	☐	_____
Joints	☐	☐	_____
Neuro	☐	☐	_____

Recommendations for physical activity (physical education, intramurals or intercollegiate sports competition):

☐ Unlimited ☐ Limited If "Limited" please explain: _____

_____

PHYSICIAN'S' SIGNATURE _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER (_____) _____

PLEASE STAMP DOCTOR'S NAME AND ADDRESS

DATE OF EXAM _____

Health Report

ATHLETES ONLY

Wells College

If you are competing in intercollegiate athletics, this form needs to be completed within 6 months prior to participation!

HEALTH RECORD AND EXAMINATION TO BE COMPLETED BY M.D., D.O., P.A., C.R.N.P.

Name (Last, First, MI) _____

Age _____ Date of Birth _____ Sex _____ HT _____ WT _____

Standing BP _____ Sitting BP _____ Pulse _____

Glasses: ☐ Yes ☐ No Contact Lenses ☐ Yes ☐ No Eye Protection ☐ Yes ☐ No
Vision R _____ L _____ Anisocoria R _____ L _____

Check each item N (Normal) or A (Abnormal)

HEENT		Comments			Comments	Medications with or without a prescription
Fundoscopic Exam			Dental			
Ears			Nodes			
Mouth			Lungs			
Throat			Thyroid			
Cardiac *						
Including precordial auscultation (supine & standing) and femoral artery pulses.						
Abdomen			Neuro *			
Genitalia			Depression/Anxiety			
Hernia			Other Psychological			
Skin			Disorders			
MUSCULOSKELETAL						
Neck			Hip			
Thoracic/Lumbar			Quad/Hamstring			
Shoulder			Knee			
Elbow			Ankle/Feet			
Wrist/Hands			Gait			

*** If answered Abnormal, we will need to have further documentation from provider.**

Special Dietary/Nutrition Needs

Please identify any food/drug allergy or intolerance/reaction:

☐ Citrus ☐ Fish ☐ Shellfish ☐ Cillin's
☐ Corn ☐ Milk/Dairy ☐ Soy ☐ Ibuprofen
☐ Egg ☐ Peanut ☐ Strawberry ☐ Other

Please list any other nutrition related conditions that would indicate a special diet:

EMERGENCY CONTACT #1

Name _____ Phone Number _____ Relation _____

EMERGENCY CONTACT #2

Name _____ Phone Number _____ Relation _____

YES	NO	HISTORY
☐	☐	1. Have you ever fainted?
☐	☐	During exercise?
☐	☐	Have you had chest pain during exercise?
☐	☐	2. Family history of sudden death?
		☐ Before age 35? ☐ Before age 50? Cause _____
☐	☐	3. Have you ever had a concussion?
		How many? _____ Number of times you lost consciousness _____ Dates of concussions _____
☐	☐	4. Have you ever had heat stroke or heat exhaustion?
☐	☐	5. Do you have a history of asthma?
☐	☐	Do you use inhalers?
☐	☐	6. Do you have any allergies? (medications, bee stings, pollens, foods): _____
☐	☐	Do you use an Epipen?
☐	☐	7. Do you take any medications? (including vitamins and nonprescription drugs): _____
☐	☐	8. Do you have any chronic medical conditions? If yes, explain. _____
☐	☐	9. Have you ever been hospitalized? Explain. _____
☐	☐	Have you ever had a serious accident or injury. Explain. _____
☐	☐	10. Have you had a significant joint injury? Specify joint/date _____
☐	☐	11. Do you have an eating disorder?

***If you answered yes, you must have documentation from provider.**

I do not know of any existing physical conditions or additional health reasons that would preclude my participation in sports. I certify that the answers to the above questions are true and accurate.

STUDENT'S SIGNATURE _____ DATE _____

PHYSICIAN'S' SIGNATURE _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER (_____) _____

PLEASE STAMP DOCTOR'S NAME AND ADDRESS

DATE OF EXAM _____

☐ CLEARED FOR SPORTS NO RESTRICTIONS

☐ CLEARED FOR SPORTS WITH RESTRICTIONS

☐ NOT CLEARED

WELLS COLLEGE ATHLETIC TRAINING MEDICAL FORMS

Student-Athlete Authorization/Consent

I, _____ hereby authorize Wells College and its physicians, athletic trainers and health
Name of Student-Athlete
care personnel to disclose my protected health information, medical records and any related information regarding any injury or illnesses during my training for and participation in intercollegiate athletics to the following checked entities below:

- ☐ Wells College Community Medical Center, Athletic Trainers, Wells College Sports Medicine Staff
- ☐ College Officials (Coach, SID, Athletic Director, President)
- ☐ Parents and/or Legal Guardian
- ☐ NCAA and its employees or agents*

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

* I understand that my protected health information will be used only by the NCAA's Injury Surveillance System (ISS) for the purpose of conducting research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database that provides the NCAA, NCAA sports rules committees, athletic conferences, researchers and individual schools with summary (aggregate) injury and participation information that does not identify individual athletes or schools. The summary data provide the Association and other groups with an information resource upon which to base health and safety rules and policy and to examine the effectiveness of such efforts. I understand that while HIPAA regulations do not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA and Wells College is committed to protecting my privacy. I understand that the protected health information will be encoded before being transmitted from my institution to the NCAA and that neither the NCAA nor the ISS will identify me personally in any publication or disclosure of research results. Data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana.

This authorization/consent expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Assumption of Risk and Release

I fully understand that while playing or practicing in intercollegiate athletics for Wells College, serious injuries or death can occur. These injuries include, but are not limited to: Head, neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to internal organs, serious injury to bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I assume all risks, known and unknown, foreseeable and unforeseeable, in any way connected with my participation in Wells College intercollegiate athletics. I accept responsibility for any liability, injury, loss or damage in any way connected with my participation in intercollegiate athletics at Wells College.

I realize that during my athletic career at Wells College I have a responsibility to my own physical well being and must accurately report any injury or illness in a timely manner to the Wells College Sports Medicine Staff. This will iclude reporting any signs and symptoms of a concussion to the Sports Medicine staff and/or coach. I will follow the guidelines established by the Wells College Sports Medicine Staff for rehabilitation from any injury. If I have any questions regarding my injury or care, I will ask the Wells College Sports Medicine Staff. I will also abide by the rules of the sport in which I participate. I also understand that I must refrain from practice and play whenever restricted from participation by the Wells College Medical or Sports Medicine Staff. I realize that adherence to these responsbilities in no way assures me of avoiding or lessening all injuries, including those of catastrophic nature, but by following them, I may decrease the severity of some injuries.

My signature below indicates I have read this entire document, understood it completely, and agree to be bound by its terms. Failure to report any injuries, illnesses, or other medical problems before, during, or after my physical can cause me to have my participation in Wells College athletics revoked.

Permission to Treat Statement

I hereby grant permission to the Wells College Sports Medicine Staff to provide routine medical care to my – self/son/daughter. This care may include prevention of injuries, first aid and injury management, evaluating injuries and rehabilitating injuries. Furthermore, I do hereby authorize the Wells College Sports Medicine Staff to seek emergency medical care from outside clinicians and medical personnel and release information to the appropriate personnel if they feel it is necessary. I understand I am free to withdraw this consent, in writing, at any time.

My signature below indicates I have read this entire document, understood it completely, and agree to be bound by its terms.

Printed Name of Student-Athlete	Student-Athlete Signature	Date
Printed Name of Parent/Guardian (Required if student is not 18 or older)	Parent/Guardian Signature (Required if student is not 18 or older)	Date

WELLS COLLEGE ATHLETIC TRAINING EDUCATIONAL FORM

Concussions

A concussion is a brain injury that is very serious. They are caused by a bump, blow, jolt to the head, or by a blow to another part of the body with force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly**. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of a concussion include but are not limited to the following: Headaches, nausea, balance problems, sensitivity to light, drowsiness, amnesia, confusion, and concentration or memory problems. Signs and symptoms may show up right after the injury or can take hours or days to fully appear. If you suffer from any of these signs or symptoms, seek a member of the Wells College Sports Medicine Staff. As a student-athlete at Wells College you are required and expected to report any and all injuries. Failure to do so can result in serious health risks to yourself and others.

Any student-athletes participating in a contact sport will be required by the athletic training staff to take a baseline ImPACT test. Information on how to access and take the test will be given to the student-athlete prior to the start of the season. Each student-athlete will be required to take the baseline test only once in their career at Wells College. All testing must be done prior to the first competition. Any athletes suffering from a concussion during their career at Wells College will then be required to take ImPACT tests until baseline levels are achieved. No student-athlete diagnosed with a concussion will be allowed to participate in practice or competition until cleared by a member of the Wells College Sports Medicine Staff.

Insurance Information

All student-athletes at Wells College will be covered by a sports insurance policy. This policy will cover any athletic injury a student-athlete may receive while in season for your particular sport. The policy does contain a $2,500 deductible that must be met by your personal insurance or the mandatory Wells College blanket insurance. In order to receive this coverage, a claim form must be filled out within 60 days of the injury. Claim forms can be found in the athletic training room. The athletic trainers will help you fill out the form, but it is your responsibility for having it completed. Failure to do so may result in a loss of coverage. Any outstanding medical bills will not be the responsibility of Wells College or its employees.

More information regarding concussions, sickle cell trait, and insurance information can be found on the Wells College athletics website under the Sports Medicine tab. This information can also be found in the athletic training room on campus located behind the Schwartz Center.

My signature below indicates I have read this entire document, understand it completely, and agree to be bound by its terms. My signature also indicates that I am aware of the insurance information and will be held responsible for any and all medical bills I may incur at Wells College from my participation in athletics.

Printed Name of Student-Athlete	Student-Athlete Signature	Date
Printed Name of Parent/Guardian (Required if student is not 18 or older)	Parent/Guardian Signature (Required if student is not 18 or older)	Date

SICKLE CELL TRAIT SCREENING

The NCAA and Wells College are mandating that all student-athletes be tested for sickle cell trait, show proof of a prior test, or sign a waiver releasing the College from liability if they decline to be tested. Knowledge of sickle cell trait status can be a gateway to education and simple precautions that may prevent collapse among athletes with sickle cell trait, and allowing them to thrive in sport.

Student-Athletes need to complete one of these three options to be compliant with the NCAA and Wells College policy:

1. Schedule an appointment with either your family physician or with the Wells College Health Center (Community Medical Center) to have the sickle cell trait screening performed.

    - This test needs to be in the form of a blood test

2. Contact your pediatrician (at birth) to receive documentation showing your sickle cell trait status.

    - Infants born after 1975 in the state of NY should have been tested for sickle cell trait and therefore the documentation should be available from your family pediatrician. This initial testing date changes on a state by state basis- if born outside of NY you may not have been tested at birth.

3. Sign a waiver releasing the College, its trustees, officers, employees, agents, contractors and representatives from any and all costs, liability, expense claims, demands or causes of action on account of any loss or personal injury that might result from your participation in athletics without knowing your sickle cell trait status.

    - The signing of the waiver is not recommended. It is preferred that all student-athletes know their status to help safeguard their health and well-being during participation in athletics. We are advising all student-athletes to consult with their parent or guardian before signing the waiver.

SICKLE CELL TRAIT FACTS

Sickle Cell Trait

- Sickle cell trait is not a disease; it is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Sickle cell trait is common; more than 3 million Americans carry sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia in the muscles may cause sickling of red blood cells (red blood cells change from a normal disk shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and "logjam" blood vessels leading to collapse from the rapid breakdown of muscles starved of blood (ischemic rhabdomyolysis) and, potentially, eventually death.
- **Exertional Sickling Collapse is a medical emergency and demands immediate attention.**
- Acute rhabdomyolysis tied to sickle cell trait is one of the top three causes of non-traumatic sports deaths in high school and college athletes.

Activity Likely to Result in Sickling

- Likely sickling settings include timed runs, maximum exertion of any kind for as little as 2-3 continuous minutes without a rest, intense drills (weight lifting, running or mat drills) and other spurts of exercise after prolonged conditioning exercises, and other extreme conditioning sessions.
- Heat, dehydration, altitude, and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense.
- Common signs and symptoms of a sickle cell emergency include, but are not limited to, increased pain and weakness in the working muscles (especially the legs, buttocks and/or low back) due to insufficient blood flow to working muscles; cramping-type muscle pain; soft, flaccid muscle tone; "slump to a stop" due to weak and wobbly legs no longer able to support student-athlete; and/or immediate symptoms with no early warning signs.

Further information about sickle cell trait is set forth in the NCAA publication
Sickle Cell Trait: A Fact Sheet for Student-Athletes
http://fs.ncaa.org/Docs/health_safety/SickleCellTraitforSA.pdf

SICKLE CELL TRAIT DISCLOSURE FORM

I, _____ , affirm that I have been informed by my family physician as to my Sickle Cell Trait Status, and/or have undergone the sickle cell trait screening in the form of a blood test at the Wells College Health Center (Community Medical Center), and that my sickle cell trait status is as follows:

1. Sickle Cell Trait Positive initial _____
2. Sickle Cell Trait Negative initial _____

I, the undersigned, do hereby affirm that I have been informed of my above-noted sickle cell trait status by my family physician and/or one of the clinicians at the Wells College Health Center (Community Medical Center). If my sickle cell trait status is positive, I understand that I am required to undergo educational sessions around the topic of sickle cell trait in order to understand specific precautions that need to be undertaken due to the serious nature of the condition. The educational sessions will be administered by the Wells College Team Physician and/or a member of the Sports Medicine Team. I recognize that the College will, and agree that it may, consider my sickle cell trait status in determining the details of my participation in intercollegiate athletic activities (including training, practice and competition), such as alterations to and/or limits on traditional conditioning regimens.

_____ _____
Student-Athlete Signature (if under 18, include parent/guardian signature) Date

_____ _____
Examining Physician Signature Date

_____ _____
Examining Physician Print Name Date

_____ _____
Athletic Trainer Signature Date

_____ _____
Athletic Trainer Print Name Date

SICKLE CELL TRAIT DISCLOSURE FORM

I, _____, am a student-athlete in the sport(s) of _____ at Wells College. I am aware that participation in intercollegiate athletics at Wells College involves the risk of personal injury. I am also aware that if I have sickle cell trait, I am at an increased risk for serious illness or injury, including death, especially during physical exertion. I acknowledge that the NCAA and the Wells College Department of Intercollegiate Athletics strongly recommend that all student-athletes be tested for sickle cell trait or show the results of a prior test in order to confirm the student-athlete's sickle cell trait status, before participation in intercollegiate athletics. Additionally, I have read and fully understand the aforementioned facts about sickle cell trait and sickle cell trait testing. I have had full opportunity to ask questions concerning sickle cell trait (and testing for sickle cell trait) and to discuss the risks associated with participation in intercollegiate athletics at Wells College if I have sickle cell trait. Any questions or concerns I have, if any, have been addressed to my satisfaction.

I do not wish to undergo sickle cell trait testing as part of my pre-participation physical examination. I understand and acknowledge that participating in intercollegiate athletic activities without knowing my sickle cell trait status may increase risks of injury, illness and death associated with such participation, and may preclude precautions that might mitigate these risks. I further acknowledge that for these reasons, Wells College strongly recommends that I be tested. Nevertheless, with knowledge of these increased risks and after consultation with medical personnel deemed by me to be adequately qualified to advise me (if and to the extent I have deemed such consultation to be necessary), I have decided that I do not wish to be tested. I acknowledge, accept, and assume all risks of participating in athletic activities without knowing whether I am sickle cell trait positive, and I release Wells College and its trustees, officers, employees, agents, contractors and representatives from any and all claims I may have in the future, waive all such claims, and agree not to sue Wells College and its trustees, officers, employees, agents, contractors and representatives (the "Released Parties") for any such claims, arising out of such participation, including without limitation claims arising out of the actual or alleged negligence of any or all of the Released Parties or others. I understand and agree that this agreement is to be as broad and inclusive as is permitted by the laws of the State of New York, and that if any portion of this agreement is held invalid, the remaining terms shall continue in full force and effect. This agreement shall be binding upon me and my successors, personal representatives, heirs and assigns.

Notwithstanding the above, if Wells College believes, in its reasonable judgment, that I may be developing symptoms that could be related to sickle cell trait, Wells College may require testing and may withhold me from training, practice and/or competition until I agree to sickle cell trait testing, such testing has been conducted, and the results have been evaluated by Wells College or its designee.

I represent and certify that I have read, understood and agree to be legally bound by the foregoing agreement, waiver, and release.

Date: _____ Student-Athlete name (print): _____

Sports: _____ Student-Athlete signature: _____

Parent/Guardian Signatures Required if Student-Athlete is Under 18 Years of Age:

The undersigned represent that they are all of the above-named student-athlete parents or guardians. The signature of each parent or guardian below shall constitute (a) his or her agreement to the terms of this agreement on the student-athlete's behalf, (b) his or her agreement to the waiver, release of liability, covenant not to sue and assumption of risk provisions set forth above with respect to any rights he or she may have or subsequently acquire as a result of the student-athlete's participation as described above, and (c) his or her agreement to defend, indemnify and hold harmless the Released Parties from and against any and all claims and/or liability for loss of property, personal or bodily injury and/or death incurred by the student-athlete as a result of such participation, including but not limited to claims and/or liability arising out of the actual or alleged negligence of the Released Parties or others.

_____

Parent/legal guardian name (print)

_____

Parent/legal guardian signature

_____

Date

_____

Parent/legal guardian name (print)

_____

Parent/legal guardian signature

_____

Date

Wells College

170 MAIN STREET, AURORA, NY 13026