Franklin Pierce University

* Submit your health forms in person, online, email, or by mail only to → HEALTH SERVICES

DUE: JULY 29

HEALTH FORMS

Health Services
Office (603) 899-4130
FAX (603) 899-1050

* Student completes/signs pages 1 – 5. * Medical Provider completes/signs pages 6 & 7.

Name: _____ (_____)
LAST FIRST MIDDLE PREFERRED NAME

Date of Birth: ___/___/___ Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex
MONTH/DAY/YEAR

Gender Identification: ☐ Male ☐ Female ☐ Intersex ☐ Transgender Woman/Female ☐ Transgender Man/Male ☐ Non-Binary

☐ Other gender, please specify: _____ ☐ Preferred Pronouns _____ ☐ Choose not to disclose

Permanent Address: _____
STREET ADDRESS CITY STATE ZIP

Birthplace (Country): _____ Citizenship (if other than U.S.): _____

Home Telephone: ( ) _____ Student Mobile Phone: ( ) _____

Email: _____ Date entering Franklin Pierce: _____

If transferring, indicate college(s) attended (with dates): _____

Emergency Contact: *I give my permission to Health Services to release information to the people below in case of a medical emergency:*

Name: _____ Relationship: _____
Home Phone: _____ Business Phone: _____
Cell Phone: _____

Name: _____ Relationship: _____
Home Phone: _____ Business Phone: _____
Cell Phone: _____

CONSENT FOR EMERGENCY CARE

To be signed by student upon reaching their 18th birthday. (If you are not 18, you must report to Health Services and sign this form when you turn 18). In the event of an emergency, I hereby give permission to Health Services and its affiliated hospital to secure appropriate treatment, if necessary, and the release of insurance information for billing purposes.

* STUDENT SIGNATURE: _____

Date: _____

Signature BELOW by parent, guardian, or the healthcare proxy agent.
This is mandatory if the student is under the age of 18.

Printed Name: _____

Relationship: _____

Signature: _____

Date: _____

HEALTH INSURANCE INFORMATION

Insurance Company: _____

Insurance Co. Address: _____

_____

Insurance Co. Telephone: _____

Policy ID No.: _____

Group No: _____

Policy Holder & Relationship: _____

_____

O I have reviewed all of the information contained in Health Form, Page 1. The information disclosed is true and accurate to the best of my knowledge.

_____ _____
STUDENT SIGNATURE DATE

_____ _____
PARENT SIGNATURE *(REQUIRED IF STUDENT IS UNDER AGE 18)* DATE

Franklin Pierce University, 40 University Drive, Rindge, NH 03461

healthservices@franklinpierce.edu o.603-899-4130 f.603-899-1050

FranklinPierce UNIVERSITY

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Health Services
Office (603) 899-4130
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Personal History

1. Names and dosages of prescription drugs and herbal/sports supplements: _____
2. Names of over-the-counter medicines used: _____
3. Serious illness/surgery/handicaps: _____
4. Is there anything else Health Services should know about your medial history? _____

Allergies	Yes	No
Penicillin		
Sulfa Drugs		
Other Drugs		
Chicken Feathers/Eggs		
Horse Serum		
*Foods (Specify in "Other")		
Wasps/Bees		
Trees/Plants		
Dust/Molds		
* Other (explain)		

Surgeries	Yes	No
Appendectomy		
Tonsillectomy		
Hernia Repair		
Fractures/Orthopedics		
Handicaps/Special Needs		
Other (explain)		
Other (explain)		

For Women only	Yes	No
Irregular Periods		
Severe Cramps		
Excessive Flow		
Breast Lumps		
Other (explain)		
Medications Used:		

Do you have a present or past history of :	Yes	No	EXPLANATIONS: Describe any answers in the "yes" column. Please reference item numbers.
1. Alcoholism or Drug Abuse			
2. Anemia			
3. Anxiety, frequent worry			
4. Anorexia/Bulimia			
5. Asthma			
6. Back Problems			
7. Bleeding, abnormal			
8. Blindness/Visual Impairment/Contacts/Glasses			
9. Cancer or impaired immunity			
10. Chicken Pox (what age)			
11. Chronic Constipation/Colitis/Diarrhea			
12. Convulsions/Seizure Disorder/Epilepsy			
13. Depression, frequent			
14. Diabetes			
15. Ear Trouble/Hearing Loss/Deafness			
16. Headaches/Migraines - Type			
17. Heart Problems			
18. Hepatitis - Type ( )			
19. High Blood Pressure			
20. Kidney Disease			
21. Mononucleosis			
22. Pregnancy			
23. Sexually Transmitted Disease			
24. Skin Trouble			
25. Substance Abuse			
26. Thyroid Disorder			
27. Urinary Tract Infection, frequent			
28. Special Needs			
29. Do you smoke or use tobacco? Amount _____ Frequency _____			

FranklinPierce UNIVERSITY

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DUE: JULY 29

HEALTH FORMS

Health Services
Office (603) 899-4130
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Personal History (continued)

1. If you drink alcoholic beverages, how many per day or week? _____
2. Do you use street drugs, if so what type? _____
3. Do you exercise: Activity level: ☐ Low ☐ Moderate ☐ Strenuous If yes, type: _____
4. Have you had mental health counseling? Is so, when, and how long? _____

   _____
5. Do you consider yourself to be in: ☐ good ☐ fair ☐ poor health?

Family Medical History

Family Member	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers/Sisters					
Stepbrothers/Sisters					

Father's Name: _____ Phone No. _____

Address: _____

Mother's Name: _____ Phone No. _____

Address: _____

Other's Name and Relationship: _____ Phone No. _____

Address: _____

Do any immediate members of your family have the following?	Yes	No	Relationship	EXPLANATIONS: Please explain any answers in the "Yes" column (please reference item numbers).
1. Alcoholism or drug abuse				
2. Allergies				
3. Asthma				
4. Convulsions/Seizures				
5. Depression				
6. Diabetes				
7. Headaches/Migraines				
8. Heart Disease				
9. High Blood Pressure				
10. High Cholesterol				
11. Kidney Disease				
12. Lung Disease/TB				

O I have reviewed all of the information contained in Health Forms, Pages 2 & 3. The information disclosed is true and accurate to the best of my knowledge.

_____ _____

STUDENT SIGNATURE DATE

_____ _____

PARENT SIGNATURE (REQUIRED IF STUDENT IS UNDER 18) DATE

Health Services
Office (603) 899-4130
FAX (603) 899-1050

151:21 Patients' Bill of Rights. –

The policy describing the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider, shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual, and physical abuse and from exploitation, neglect, corporal punishment, and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

XXII. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.

XXIII. (a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.

(b)(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;

(B) The presence of visitors would interfere with the care of or rights of any patient;

(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or

(D) Visitors are noncompliant with written hospital policy. (2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph. (c) A health care facility may require visitors to wear personal protective equipment provided by the facility or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph. (d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility. (e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph. (f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

(1) Informational materials explaining the rights specified in this paragraph;

(2) The patients' bill of rights which applies to the facility on its website; and

(3) Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:

(1) Giving a visitor individual access to a property or location controlled by the health care facility;

(2) Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;

(3) The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility. **Source.** 1992, 78:1. 1997, 252:1, 2014. 2019, 332:6, eff. Oct. 15, 2019. 2020, 39:61, 62, eff. Jan. 1, 2021. 2022, 52:1**, eff. May 20, 2021; 304:2, eff. July 1, 2022.**

O **I have read The Patient Bill of Rights** _____ **(Student Signature)** _____ **(Date)**

Parent signature required if student is not 18 yrs. of age _____ _____ **(Date)**

Franklin Pierce University

DUE: JULY 29

Health Services
Counseling and Outreach
Student Accessibility Services

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Date: _____

STUDENT. In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) my records, conversations, diagnoses, and treatment are confidential and cannot be released until I grant written permission to **Health Services, Counseling and Outreach,** and **Student Accessibility Services.**

Student's Name: _____ Date of Birth: _____
(Please Print)

Student ID#: _____ Campus PO Box#: _____ Cell Phone#: (____) _____ Email _____

Home Address: _____

AUTHORIZATION. I authorize **Health Services, Counseling and Outreach,** and **Student Accessibility Services** to disclose the following:

- My medical-related information
- My counseling-related information
- My student accessibility-related information

PURPOSE. The reason for this authorization is: ***(check one)***

- ☐ To share information as it pertains to my accommodations, treatment and/or medications.
- ☐ Information pertaining to my mental health or request for accommodations is the only information to be shared and not the content of therapeutic sessions nor my general health care treatment.
- ☐ Other: _____

TERMINATION. This authorization remains active for the entirety of my attendance at Franklin Pierce University.

ACKNOWLEDGEMENT OF RIGHTS. I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I understand that uses and disclosures already mad based upon my original permission cannot be taken back. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Student signature: _____ Date: _____

IF STUDENT IS UNABLE TO SIGN DUE TO: ***(check one)***

- ☐ – **Being a Minor.** Patient is ____ years of age and considered a minor under state law.
- ☐ – **Being Incapacitated.** Patient is incapacitated due to: _____
- ☐ – **Other:** _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other: _____

Signature of Representative: _____

Print Name: _____ Date: _____

Franklin Pierce University

*** NOTE:** A copy of your physical from your medical provider is acceptable as long as the information required on the signed/dated form is comparable to our requirements.

DUE: JULY 29

HEALTH FORMS

Health Services

Office (603) 899-4130

FAX (603) 899-1050

PHYSICAL FORM *(To be completed by MD/NP/PA/DO)*

Examiner: **Please complete the physical examination below and comment on all pertinent findings and be sure all information is complete.**

Name: _____ (_____)
LAST FIRST MIDDLE PREFERRED NAME

Date of Birth: ____/____/____ **Sex Assigned at Birth:** ☐ Male ☐ Female ☐ Intersex
MONTH/DAY/YEAR

Gender Identification: ☐ Male ☐ Female ☐ Intersex ☐ Transgender Woman/Female ☐ Transgender Man/Male ☐ Non-Binary

☐ Other gender, please specify: _____ ☐ Preferred Pronouns _____ ☐ Choose not to disclose

Race: _____ **Ethnicity:** _____

Participating in an intercollegiate sport? ☐ Yes ☐ No (if yes, which sport?): _____

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____ **Respirations:** _____

Vision: With/ Without glasses: Right 20/_____ Left 20/_____

Hearing: Right Normal: ☐ Yes ☐ No Left Normal: ☐ Yes ☐ No Hearing Aid: ☐ Yes ☐ No

List all current medications: _____

List all ALLERGIES to food, medications, or other: _____

No.	System	WNL	Abn	Briefly describe abnormality
1.	Skin	☐	☐	
2.	Eyes	☐	☐	
3.	Ears	☐	☐	
4.	Nose, throat	☐	☐	
5.	Neck, thyroid	☐	☐	
6.	Lymphatics	☐	☐	
7.	Chest, Breasts, Lungs	☐	☐	
8.	Heart, rate/rhythm/sounds	☐	☐	
9.	Abdomen	☐	☐	
10.	Genitalia, Rectal	☐	☐	
11.	Extremities, back, spine	☐	☐	
12.	Neurological	☐	☐	
13.	Psychological	☐	☐	

The applicant is in ☐ excellent ☐ good ☐ poor health.

The following abnormalities should be noted: _____

*Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: _____; Results: _ mm. ☐ Low risk (no PPD done)

REQUIRED: **Medical Provider Contact Information:**

Print Name: _____ MD/NP/PA/DO

_____
STREET ADDRESS CITY STATE ZIP

Office Phone: (____) _____ Fax: (____) _____

_____
MEDICAL PROVIDER SIGNATURE DATE OF MEDICAL EXAM

FranklinPierce UNIVERSITY

HEALTH FORMS
Health Services
Office (603) 899-4130
FAX (603) 899-1050

*** NOTE:** A copy of your immunization from your medical provider is acceptable as long as the information required on the signed/dated form is comparable to our requirements.

DUE: JULY 29

IMMUNIZATION FORM

*** Immunization Form to be completed and signed by MD/NP/PA/DO.**

Name: _____ Date of Birth: _____
LAST FIRST MIDDLE

Address: _____
STREET ADDRESS CITY STATE ZIP

Required Immunizations	Date	Date	Titer / Date
1. **M.M.R.** (Measles, Mumps, Rubella) **Two doses of measles required.** Dose #2 given at least one month after first dose OR report of positive immune titer			
2. **Tetanus-Diphtheria:** *Required* Primary Completed Series **Booster within the last 10 years**	Td	Tdap	
3. **Varicella** (Two doses required)	Date	Date	Disease/Date
4. **Meningococcal Quadrivalent conjugate (MenACWY)** required for all students on campus. **If initial dose was given under 16 yrs. of age, a conjugate booster dose is required at >16-21 yrs.**	Quadrivalent Conjugate #1/Date	Quadrivalent Conjugate #2/Date	
5. **COVID** Immunization ***(First 2 doses. Specify brand names)***	Date	Date	

6. * **Tuberculosis Screening** ***(within one year of acceptance to Franklin Pierce University)***

a)	Have you been in contact with a person who has TB?	☐ Yes ☐ No
b)	Do you have signs or symptoms of active tuberculosis diseases?	☐ Yes ☐ No
c)	Were you born in another country and arrived in the past 5 years?	☐ Yes ☐ No
d)	Are you a member of a high-risk group?	☐ Yes ☐ No

Ask student/client questions a – d and check the appropriate boxes "YES" or "NO".

*** If boxes are "No" STOP here. If YES,** PPD Skin Test required.

Previous BCG vaccination should not preclude testing a member of a high-risk group (GFT, GIT, or CXR).

e)	Tuberculin Skin Test (PPD) Record of actual MM of induration transverse diameter, if not duration, write "0"	Date given	Date read	Result
f)	**Chest X-ray QUANTIFERON GOLD (if PPD skin test is "positive")**	Result: Normal ☐	Result: Abnormal ☐	Date of X-Ray:

Strongly Recommended			
1. **Meningitis B** (two or three doses depending on brand)	Vaccine/Date		
2. **Hepatitis B** (three doses of vaccine or Pos. Hep B surface antibody)	#1 Date:	#2 Date:	#3 Date:

MEDICAL PROVIDER SIGNATURE DATE

Franklin Pierce University Athletics

Athletic Training Health Form 2024-2025

- This form must be completed prior to a student/athlete's first practice, or they will not be able to participate in athletics (practice, games, lift/conditioning sessions).
- This information is confidential and will be located in the Franklin Pierce Athletic Training Facility unless otherwise released with your permission.
- If any portion of this form is submitted incomplete, you will not receive medical clearance until completed fully.
- The Franklin Pierce Athletic Training Staff's priority is the health and safety of all student/athletes. The Franklin Pierce Athletic Training Staff has the right to withhold any student/athlete from participating in athletics (practices, games, lift/conditioning sessions) due to health-related issues.

Student/Athlete Name (first and last):_____

Sport(s):_____ Date of Birth (mm/dd/yyyy):_____

Birth Gender:_____ Preferred Gender:_____

Student ID Number:_____ Cell Phone Number:_____

Address (street address, city, state, zip code, country): _____

_____

On-campus Resident Hall; Room number; Mailbox number:_____

Class: _____ Expected Graduation Year:_____

* I give permission for Franklin Pierce University Athletic Training to contact the following people in the event of a medical emergency:

Parent/Guardian (Name, relationship, cell phone number):_____

Parent/Guardian (Name, relationship, cell phone number): _____

Emergency Contact (other than parent/guardian) (Name, relationship, cell phone number):

_____

Please list any medical conditions (diabetes, asthma, epilepsy, etc.): _____

*If you have a medical condition, please list any medical devices or medications you require:_____

Please list any allergies (i.e. peanuts, shellfish, bee stings, etc.):_____

*If you have allergies, do you have an EpiPen? ◯ **YES** ◯ **NO**

Please list any medications:_____

Please Note: The use of an anabolic agent, hormone and metabolic modulator, peptide hormone, growth factors, related substances and mimetics must be approved by the NCAA before the student/athlete is allowed to participate in competition while taking these medications. Please contact your Athletic Trainer if you are taking any of these substances.

Health Insurance Information

*** FRANKLIN PIERCE UNIVERSITY STUDENT/ATHLETES ARE REQUIRED TO HAVE MEDICAL INSURANCE ***

Medical Insurance Company Name:_____

Medical Insurance Company Address and Phone Number :_____

Policy Number: _____

Name and relationship to Insured (self/mother/father/other):_____

*** You must Upload Front and Back of your Insurance Card to Medicat ***

Franklin Pierce University provides accidental secondary medical coverage for student/athletes for athletically related injuries (i.e. practices, competitions, strength, and conditioning sessions). This is a secondary insurance policy and the student/athlete's primary insurance must be billed first.
Coverage is subject to specific policy terms and conditions and includes certain restrictions and exclusions:

1. All athletically related medical injuries need to be reported to the team's Athletic Trainer within 24 hours
2. All medical expenses must be submitted to the student/athlete's primary medical insurance first
3. Any medical bills the student receives must be submitted to the Athletic Trainer as soon as the bill is received (otherwise bill may not be paid)

Please note that Franklin Pierce University assumes no responsibility whatsoever for any uninsured expenses, and it is required by the university that the student have coverage through a primary health insurer to avoid possible, significant out-of-pocket expenses in the event of injury.
Please also note that the NCAA's Catastrophic Injury Insurance Program covers student/athletes who are catastrophically injured (medical bills totaling more than $90K) while participating in intercollegiate athletic activity (subject to all policy and terms and conditions).

Concussion Information

Concussions are mild traumatic brain injuries caused by a blow to the head or body resulting in the brain moving rapidly in the skull. Loss of consciousness is not always an indicator of the severity of a concussion. If concussions are not managed properly severe problems can occur that may be long lasting and can even lead to paralysis and possibly death. Recognition of signs and symptoms of concussions are key to proper diagnosis and treatment.
Possible symptoms of a concussion are:

- Headache
- Confusion
- Dizziness
- Nausea
- Trouble Sleeping
- More Emotional/Irritable
- Ringing in the ears
- Double or Blurred Vision
- Sensitivity to Light or Sound
- Feeling like you are in a fog

If a student/athlete has suffered 2 concussions in one season, or a total of 3 in one calendar year, the Franklin Pierce Athletic Training staff will require the student athlete to be cleared by a physician before return to play. To protect the student athlete's health, the Athletic Training staff also has permission to require the student athlete to seek medical attention following a concussion.

How many diagnosed concussions have you had previously? _____

How many diagnosed concussions have you had in the past calendar year?_____

Please list date of last diagnosed concussion (if none write "NA"):_____

How long was recovery from last concussion (if none write "NA"):_____

Have you ever been hospitalized for a concussion/head injury? _____

*If yes, please explain and list date: _____

Have you ever lost consciousness due to a head injury or concussion? _____

*If yes, please explain and list date:_____

Do you have chronic migraines or headaches?_____

*If yes, please explain: _____

Personal Health Information and History

Pre-Participation Medical Clearance: All intercollegiate athletes must be medically cleared by a member of the Franklin Pierce Athletic Training Staff prior to the start of each sport/season he/she chooses to participate in.

The personal health information and history is designed to assist the Franklin Pierce Athletic Training Staff in providing quality athletic health care to each individual student/athlete. Please complete the information below truthfully and completely. Please provide dates and details for each yes response. The information you provide is confidential. Prior to the start of your traditional season a member of the Franklin Pierce University Athletic Training Staff will review your medical history. If yes responses are not adequately explained, further interviewing will be necessary before medical clearance is granted.

Please note any surgery or significant injury (broken bones, high grade sprains/strains, etc.) that occurred in the past calendar year will require a doctor's note for athletic participation

Current height in feet/inches (i.e. 5'5"): _____Current weight in pounds (i.e. 150 lbs.): _____

Franklin Pierce University Athletics

► Please check √ Yes or No to the following questions and explain if you answer *Yes*.

Have you ever had, or do you currently have any of the following?

Anemia: ◯ Yes ◯ No If yes, are you on iron supplements:_____

_____

High or Low Blood Pressure: ◯ Yes ◯ No If yes, please list any medications: _____

_____

Arthritis: ◯ Yes ◯ No If yes, please explain: _____

_____

Mononucleosis "mono" in the past year: ◯ Yes ◯ No If yes, please list date: _____
(If yes, please provide the Franklin Pierce Athletic Training Staff with an athletic clearance note)

Breathing Difficulties: ◯ Yes ◯ No If yes, please explain: _____

Chest Pain with exercise: ◯ Yes ◯ No If yes, please explain: _____

Dizziness or fainting with exercise: ◯ Yes ◯ No If yes, please explain: _____

Childhood Illness: ◯ Yes ◯ No If yes, please explain: _____

Dental appliances or loss of permanent tooth: ◯ Yes ◯ No If yes, please explain: _____

Contact/Glasses: ◯ Yes ◯ No If yes, please explain: _____

Depression or Anxiety: ◯ Yes ◯ No If yes, please explain: _____

History of Substance Abuse: ◯ Yes ◯ No If yes, please explain: _____

Diagnosed with eating disorder of disordered eating: ◯ Yes ◯ No If yes, please explain: _____

_____

Epilepsy and/or seizures: ◯ Yes ◯ No If yes, please explain: _____
You must also provide an athletic clearance note and Standing Orders

Heat Illness: ◯ Yes ◯ No If yes, please explain: _____
Heart Condition or heart murmur: ◯ Yes ◯ No If yes, please explain: _____
You must also provide an athletic clearance note

Hernia: ◯ Yes ◯ No If yes, please explain: _____

Hepatitis: ◯ Yes ◯ No If yes, please explain: _____

Franklin Pierce University Athletics

Hypoglycemia (low blood sugar): ◯ Yes ◯ No If yes, please explain: _____

Loss or absence of an organ: ◯ Yes ◯ No If yes, please explain: _____

Injury to the eye, face, or nose: ◯ Yes ◯ No If yes, please explain: _____

Injury to the neck: ◯ Yes ◯ No If yes, please explain: _____

Injury to back or spine: ◯ Yes ◯ No If yes, please explain: _____

Injury to abdomen, chest, or ribs: ◯ Yes ◯ No If yes, please explain: _____

Injury to the upper arm shoulder: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Injury to the elbow: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Injury to the forearm or wrist: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Injury to the hand or fingers: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Injury to the hip, pelvis, or thigh: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Injury to the knee: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Injury to the lower leg or ankle: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Injury to the foot: ◯ Yes ◯ No Left _____ Right _____ Both _____

If yes, please explain and dates: _____

Franklin Pierce University Athletics

Any medical surgeries in the past 12 months: ◯ Yes ◯ No

If yes, please explain and list date: _____
You must also provide an athletic clearance note

Do you take any supplements or vitamins: ◯ Yes ◯ No

If yes, please list: _____

Do you wear any protective braces or equipment: ◯ Yes ◯ No

If yes, please list: _____

Do you currently have an unhealed injury: ◯ Yes ◯ No

If yes, please explain: _____

Weight change (+/-) 15lbs over one year: ◯ Yes ◯ No

If yes, please explain: _____

FEMALES ONLY: Irregular or loss of menstruation? ◯ Yes ◯ No
How long between menses:_____

Illness, injury, disease, or disorder not mentioned previously: ◯ Yes ◯ No

If yes, please explain: _____

Have you ever been restricted from participating in athletics: ◯ Yes ◯ No

If yes, please explain: _____

Does an immediate member of your family have any medical conditions: ◯ Yes ◯ No

If yes, please explain: _____

Are you currently taking any ADD/ADHD medications? ◯ Yes ◯ No
If yes, Newcomers please have your doctor complete the NCAA Medical Exception Form:
https://ncaaorg.s3.amazonaws.com/ssi/substance/SSI_MedicalExceptionReportingForm.pdf

Physical

NCAA Bylaw 17.1.5 Mandatory Medical Examination requires all student athletes to have a physical prior to their initial season of eligibility or trying out for a team within 6 months prior to physical activity or the date of classes. A physician, physician assistance, or nurse practitioner must complete this physical.

Upload copy of physical that is no older than 6 months to Medicat

Sickle Cell Testing

Per NCAA legislature 17.1.5.1 Sickle Cell Solubility Test. The examination or evaluation of student/athletes who are beginning their initial season of eligibility and students who are trying out for a team shall include a sickle cell solubility test (SST),unless documented results of a prior test are provided to the institution. Someone with the sickle cell trait can still compete in athletics. Sickle cell trait only becomes a threat in certain rare situations in which athletes push the limits of their physical conditioning. Being aware of the trait and taking proper precautions can help trait carriers enjoy successful and healthy athletic careers.

More information can be found at:
https://ncaaorg.s3.amazonaws.com/ssi/other/SSI_NCAASickleCellTraitforSA.pdf

How to obtain your sickle cell solubility test:

1. Contact your pediatrician (part of newborn screening for domestic students)
2. Make an appointment at a local Quest Diagnostics (https://sicklecelltesting.pwnhealth.com/)

Franklin Pierce University is not financially responsible for any cost associated with obtaining a sickle cell solubility test. *Upload copy of sickle cell solubility test results to Medicat*

Student/Athlete Information

I the undersigned,

1) Certify to the best of my knowledge that my answers to the questions of this health history screening are complete and accurate.
2) Grant permission to the Franklin Pierce Athletic Training Staff, personnel or agents (i.e. Coaches and Strength and Conditioning Staff) to secure necessary and appropriate emergency and non-emergency medical care.
3) Understand that having passed a medical evaluation does not necessarily mean that I am physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify me at the time of said evaluation.
4) Understand that if I am removed from a practice or game or willingly leave a practice or game due to an injury or illness, that I must have appropriate written medical clearance before returning to participation.
5) I understand that it is my responsibility to repost any injury, illness, or symptoms to the Franklin Pierce Athletic Training Staff as soon as the injury/illness occurs or as soon as symptoms are experiences. I also understand that failure to report injury/illness/symptoms in a timely manner may increase the risk of complications and impedes the ability of the Franklin Pierce Athletics Training Staff to provide timely and adequate treatments.

Acknowledgement of Risk:

I understand that athletic participation has risks. Risks of athletic participation include but are not limited to significant joint or bone injury, brain or spinal cord injury, internal organ injury or death. I understand that these risks can be minimized but not eliminated during athletic participation. I am willing to accept those risks and will not hold Franklin Pierce University responsible for any injuries I sustain while participating in intercollegiate practices and contests while enrolled at Franklin Pierce University.

I give permission to the Franklin Pierce Athletic Training Staff to speak with the Strength and Conditioning Staff, Coaches, Team Physicians or Athletic Administration about my injuries, treatment, or illnesses on a need-to-know basis.

I allow for the exchange of all medical information between Franklin Pierce Health Service Staff and Franklin Pierce Athletic Training Staff. ◯ Yes ◯ No

Student/Athlete Signature:_____ **Date** (mm/dd/yyyy) _____

Signature of Parent/Guardian: _____ (*If Student/Athlete is under 18 years of age)