New England Newborn Screening Program
UMass Chan Medical School
Biotech 4, 2nd Floor
377 Plantation Street
Worcester, MA 01605-2300
774-455-4600 (office)
774-455-4657 (fax)

SICKLE CELL REQUEST FORM FOR STUDENTS BORN IN MASSACHUSETTS

IF THE STUDENT WAS NOT BORN IN MASSACHUSETTS, PLEASE CONTACT THE NEWBORN SCREENING OFFICE FOR THE STATE IN WHICH THE STUDENT WAS BORN

The NCAA requires college athletes to provide proof of their sickle cell trait status. Primary Care Providers may order sickle cell testing or can refer patients to private labs, such as Quest Health. (Pricing and locations may be found on the Quest Health website; search for "Sickle Cell Trait Screen.")

SECTION I (*please print student name)*

Student/Patient Name: _____ Student/Patient's Date of Birth: _____
Birth Order (if one of multiple birth): _____

Mother's Full Name at Time of Student's Birth: _____

Hospital of Birth: _____ City/State of Birth: _____

_____

Please fax Sickle Cell Screening Results to: [ ] Student [ ] Parent [ ] Provider [x] Organization listed in Section III

Please send report to fax #: 413-755-6045

Phone # for follow up questions: 413-755-4230

IF YOU ARE A STUDENT AND YOU WANT US TO SEND THE REPORT TO YOU, STOP HERE AND FAX REQUEST TO 774-455-4657

Providers: By making this request, you certify that you are the current health care provider for the patient below.

Practice Name: _____ Attn: _____

IF YOU ARE A PROVIDER, STOP HERE AND FAX REQUEST TO 774-455-4657

Sections II-VI must be completed if report is to be sent to a party other than the student or provider

Students who want the **New England Newborn Screening Program** to share information about them with another person or organization, must fill out all of the sections below and fax both pages of this release form. If any sections are left blank, the permission will not be valid, and we will not be able to share information with the person(s) or organization you listed on this form.

Forms that are missing information may result in a delay.

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SECTION II (*please print student name)*

I, _____, give my permission to The New England Newborn Screening Program, UMass Chan Medical School, 377 Plantation Street, Worcester, MA 01605-2300, Phone: 774-455-4600 and Fax: 774-455-4657, to share only my newborn sickle cell screening results with the person(s) or organization that I list in Section III below.

SECTION III – Who May Receive My Information

The New England Newborn Screening Program may share **my newborn sickle cell screening results** with this person(s) or organization:

Name: Springfield Technical Community College

Organization: Health & Wellness Center

Address: One Armory Square, Springfield MA 01105

Fax: 413-755-6045 Phone: 413-755-4230

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION IV – Signature **Please sign and date this form and print your name.**

_____ _____

Student Signature **Date**

_____

Print Student Name

If this form is being filled out by someone who has the legal authority to act for the student (such as the parent of a minor child, a court appointed guardian or executor, or health care agent), please

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Relationship to the student: _____

Please provide any documents setting forth the legal authority, for example copies of an official birth certificate.

SECTION V – Reason for Sharing this Information:

Participation in Athletics: X Other: _____

SECTION VI – How Long This Permission Lasts

This permission to share my information is good until (indicate date): 10/30/30

If I do not list a date, this permission will last for one year from the date it is signed.

I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to **The New England Newborn Screening Program, UMass Chan Medical School, 377 Plantation Street, Worcester, MA 01605-2300, Phone: 774-455-4600 and Fax: 774-455-4657. If the information has already been given out by the New England Newborn Screening Program, I understand that it is too late for me to change my mind and cancel the permission.**

Forms that are missing information may result in a delay.