Cornell University

Cornell Health
Sports Medicine

110 Ho Plaza
Ithaca, New York 14853-3101
t. 607.255.5155
f. 607.255.0269
www.health.cornell.edu

Sports Clearance Process for Cornell Student Athletes

The Sports Medicine team welcomes you to Cornell. We look forward to supporting your health, well-being, and performance as an athlete and student.

To protect the health of intercollegiate student athletes, Cornell requires *every* athlete to receive a formal medical clearance *each year*. *Follow these instructions thoroughly* to ensure a timely process.

You will not be able to participate with your team until you complete this process.

TWO REQUIRED FORMS:

1. **You must complete both the Health History Form and the Sports Clearance Form IN FULL.**
   Keep a copy for your records.
2. **Your health care provider must provide the following**:
   - For the Health History Form:
     - ☐ Verification of immunizations.
     - ☐ Completion of Part 3 in its entirety, documenting physical exam conducted after March 1, 2017; must include visual acuity and vital signs. We will not accept substitute office notes or other exam forms. Cross country and mid / long distance runners: we recommend a baseline CBC, ferritin, and 25-Hydroxy Vitamin D level be obtained and results attached to your form.
     - ☐ Documentation of your test result for Sickle Cell Trait.
     - ☐ Health care provider contact information and signature.
     - ☐ If you are on medication for ADD/ADHD, the medical exception form (*see below*).
   - For the Sports Clearance Form:
     - ☐ Health care provider contact information, signature, and recommendation regarding your participation in intercollegiate sports. If you have seen a cardiologist, please include his/her recommendations regarding your participation in intercollegiate sports.
     - ☐ Relevant chart (including surgery) notes and lab, Xray, CT, MRI, and DEXA scan reports.
     - ☐ Cardiology screening documents: For any "yes" answers in Section F, you must provide notes from your cardiologist or primary care provider (chart notes, EKG, echocardiogram, stress, echo, or other reports).
     - ☐ Records from your health care provider(s) should be mailed or faxed to:

       Cornell Health (Attn: Sports Medicine) Address: 110 Ho Plaza Ithaca, NY 14853-3101
       Fax: 607.255.0269
   - If you do *not* provide documentation of the physical exam for the Health History Form, you will be required to have a physical at Cornell Health. If there are significant abnormalities on your physical exam or on this form that have not been addressed by your health care provider, further evaluation may be necessary.
3. **Mail by the deadline** your Sports Clearance Form and Health History Form (*together in one envelope*):
   June 16 for fall first-year entrants; August 1 for fall transfer students, and December 20 for spring 2017 entrants

ATHLETES WITH ADD/ADHD: Submit health care provider documentation with health forms.

The NCAA requires documentation of ADD/ADHD diagnosis and treatment to allow for a medical exception from the NCAA ban on the use of stimulants. **This form must be completed by your health care provider and submitted** with your Health History and Sports Clearance Forms. Download the medical exception form and instructions from our website: go to *health.cornell.edu* [search: sports clearance].

ImPACT CONCUSSION BASELINE TEST

All entering athletes must complete this test before coming to campus.

ImPACT is a test of cognitive function including memory and reaction time. We use this tool to support the recovery of athletes in the event of a concussion or head injury. Review the attached instructions now to complete it on time.

NEXT STEPS

1. **Activate your new Cornell email address.**
   This is how we will communicate with you.

2. **Check *myCornellHealth.***
   After you complete all of these requirements, the Sports Medicine Team will begin the medical review process. If we require further information or action from you, **we will contact you via <u>your new Cornell email address</u>** and direct you to *myCornellHealth*.

   This secure web portal facilitates confidential and timely communication between Cornell Health and those who use our services. You can get to it from any page on the Cornell Health website: *health.cornell.edu*. When you receive an email directing you to *myCornellHealth,* **go right away to read your secure message**. You will be asked to enter your Cornell ID and date of birth to log into your secure account.

3. **Check your Athletic Compliance and Eligibility profile.**
   Your team will be scheduled at a specific time for Sports Clearance at Cornell Health. A few days prior to your team's assigned clearance date, please check your Athletic Compliance and Eligibility profile. If you are pre-cleared, you *do not* have to report to Cornell Health on the day of your team's Sports Clearance. If you are *not* pre-cleared, you must report to Cornell Health with other members of your team.

4. **Contact us if you have any questions or concerns**
   If you need more information or have any concerns about your health and well-being, please talk with your coach or contact the Sports Medicine team (search "Sports Medicine" at *health.cornell.edu*).

The Sports Clearance Process is required for students planning to participate in one or more INTERCOLLEGIATE / NCAA SPORTS TEAMS:

Baseball
Basketball
Cross Country
Equestrian
Fencing (Women's)
Field Hockey
Football (Sprint)
Football (Varsity)
Golf
Gymnastics (Women's)
Ice Hockey
Lacrosse
Polo
Rowing
Sailing (Women's)
Softball
Soccer
Squash
Swimming/Diving
Tennis
Track
Volleyball
Wrestling

CLUB SPORTS PARTICIPANTS do <u>not</u> participate in the sports clearance process.

CORNELL HEALTH SPORTS MEDICINE
110 Ho Plaza, Ithaca, New York 14853-3101
Phone: 607.255.5156 Fax: 607.255.7786

SPORTS CLEARANCE FORM

Today's Date _____ Name _____

Sport(s) _____ Cornell ID _____

Address _____ DOB _____

E-mail Address _____ Home Phone _____ Cell Phone _____

Personal Physician _____ Physician Phone & Fax _____/_____

INSTRUCTIONS: You must complete this form IN FULL, answering all questions and explaining any abnormalities.

A. INJURIES *Check and explain in the space provided below.*

List X-rays, MRI's, CT's, injections, rehabilitation, physical therapy, brace, cast, etc. and give approximate dates.

✸ If injury was within the last 2 years, please provide chart notes and radiology reports.

		INJURY			
		None	Old	Current	Approx. Date
1.	Shoulder/Elbow (e.g., dislocation, rotator cuff, AC separation) _____	☐	☐	☐	_____
2.	Arm/Wrist/Hand/Finger (e.g., fractures) _____	☐	☐	☐	_____
3.	Neck (e.g., burners, pinched nerve) _____	☐	☐	☐	_____
4.	Ribs/Abdomen _____	☐	☐	☐	_____
5.	Low back pain (e.g., herniated disc) _____	☐	☐	☐	_____
6.	Leg/Hip (e.g., quadriceps, hamstring strain) _____	☐	☐	☐	_____
7.	Knee (e.g., ligament, meniscus, patella) _____	☐	☐	☐	_____
8.	Lower leg (e.g., shin splints, calf strain) _____	☐	☐	☐	_____
9.	Ankle/Calf/Foot/Toe (e.g., sprain, Achilles) _____	☐	☐	☐	_____
10.	Stress Fractures _____	☐	☐	☐	_____

Explain: _____

_____

_____

B. SURGERIES *List all surgeries and approximate dates.*

✸ If surgery was in the past year, provide a summary, copies of surgical notes, and notes that cleared you to return to your sport.

Type of Surgery _____ Date _____

_____ Date _____

EXPLAIN ALL "YES" ANSWERS IN THE SPACE PROVIDED ON NEXT PAGE.

C. NEUROLOGICAL ISSUES

		Yes	No
1.	Have you ever had a head injury or concussion? _____	☐	☐
	If yes, list all dates _____		
	Describe any memory loss _____		
	Describe any problems in the days afterward (e.g. confusion, headache, concentration)? _____		
	How long did it take you to recover? _____		
	Describe any problems you are still having _____		
2.	Have you been hit in the head and been confused or lost your memory? _____	☐	☐
	If yes, describe _____		
3.	Have you ever had a seizure (e.g. epilepsy)? If yes, date of last seizure _____	☐	☐
	List all current medications you take to prevent seizures _____		
4.	Do you have frequent or severe headaches? _____	☐	☐
	Date last evaluated by health care provider _____		
	List all headache medications that you take _____		
5.	Do you have headaches with exercise? _____	☐	☐
6.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? _____	☐	☐
7.	Have you ever been unable to move your arms or legs after being hit or falling? _____	☐	☐
8.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? _____	☐	☐

Student Name (*please print*)_____

EXPLAIN ALL "YES" ANSWERS IN SECTION I BELOW.

D. SIGNIFICANT HEALTH ISSUES	**Yes**	**No**
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Have you ever been hospitalized overnight for reasons other than surgery?	☐	☐
3. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? _____	☐	☐

E. GENERAL MEDICAL ISSUES	**Yes**	**No**
1. Are there any current prescription medicines or over-the-counter medicines that you take regularly? (*list*)_____	☐	☐
2. Do you have any allergies to medicines?_____	☐	☐
3. Do you have any severe allergies to food or insect stings?_____	☐	☐
4. Do you have seasonal allergies (hay fever) or other allergies that require medicines?_____	☐	☐
5. Have you ever had any rash or hives develop during or after exercise?_____	☐	☐
6. Do you cough, wheeze, or have breathing difficulty during or after exercise?_____	☐	☐
7. Do you have asthma? _____	☐	☐
8. Have you ever used an inhaler, or taken asthma medicine?_____	☐	☐
9. Is there anyone in your family who has asthma?_____	☐	☐
10. Do you have any current skin problems (e.g. athlete's foot, ringworm, impetigo)?_____	☐	☐
11. Have you ever had a herpes skin infection?_____	☐	☐
12. Have you had infectious mononucleosis (mono) within the past month?_____	☐	☐
13. When exercising in the heat, do you have severe muscle cramps or become ill? _____	☐	☐
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (e.g., knee brace, special neck roll, foot orthotics, retainer on your teeth, goggles, face shield, or hearing aid)?_____	☐	☐
15. Have you ever had a detached retina or any severe eye trauma?_____	☐	☐
16. Is your vision in either eye worse than 20/40 even with correction (contacts or glasses)?_____	☐	☐
17. Do you feel significantly stressed or depressed?_____	☐	☐
If yes, are you taking any medications? (*list*)_____	☐	☐
18. Do you have a history of bleeding disorders such as hemophilia, Von Willebrand disease or other factor deficiencies? ✸ *If yes, provide documentation*.	☐	☐
19. Have you ever been diagnosed with ADD/ADHD? _____	☐	☐
If yes, are you taking any medications? (*list*)_____	☐	☐
20. Do you have any other ongoing medical problems for which you are being treated (e.g. anemia, asthma, diabetes, thyroid disorder, etc.)? _____	☐	☐

F. CARDIOLOGY SCREENING ✸ *For all YES answers, you must provide copies of chart notes or test reports.*	**Yes**	**No**
1. Have you ever passed out, or nearly passed out, during or after exercise? *If yes, list dates.* _____	☐	☐
2. Have you ever had discomfort, pain or pressure in your chest during exercise? _____	☐	☐
3. Does your heart race or skip beats during exercise? _____	☐	☐
4. Has a doctor ever told you that you have any of the following? *If yes, please check all that apply*: ☐ high blood pressure ☐ heart murmur ☐ high cholesterol ☐ heart infection		
5. Has a doctor ever ordered a test for your heart? (e.g. ECG, echocardiogram)_____	☐	☐
6. Has anyone in your family died for no apparent reason? _____	☐	☐
7. Has any family member/relative died of heart problems or sudden death before age 50? _____	☐	☐
8. Has a physician ever denied or restricted your participation in sports for any heart problems? _____	☐	☐
9. Is there any family history of Marfan's Syndrome, cardiomyopathy or long QT syndrome, or other heart problem?_____	☐	☐

G. WOMEN'S HEALTH (*Females only.*)	**Yes**	**No**
1. Have you ever had a menstrual period?	☐	☐
2. How old were you when you had your first menstrual period? _____		
3. When was your most recent menstrual period? _____		
4. How many periods have you had in the past 12 months? _____		
5. Are you presently taking any female hormones (estrogen, progesterone, birth control pills?	☐	☐
6. Do you worry about your weight?	☐	☐
7. Are you trying to, or has anyone recommended that you gain or lose weight?	☐	☐
8. Are you on a special diet, or do you avoid certain types of food?	☐	☐
9. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐
10. Have you ever had an eating disorder?	☐	☐
11. Have you ever had a stress fracture?	☐	☐
12. Have you ever been told you have low bone density (osteopenia or osteoporosis)?	☐	☐

H. MEN'S HEALTH (*Males only.*)

		Yes	No
1.	Do you worry about your weight?	☐	☐
2.	Are you trying to, or has anyone recommended that you gain or lose weight?	☐	☐
3.	Are you on a special diet, or do you avoid certain types of food?	☐	☐
4.	Have you ever had an eating disorder?	☐	☐
5.	Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐

I. PROVIDE AN EXPLANATION FOR ALL "YES" ANSWERS HERE.

_____

_____

_____

_____

J. HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

- This section must be completed by your health care provider.
- Health care provider contact information and signature is required for completion of this form.
- Please be aware that final sports clearance decision will be made by the Chief of Sports Medicine at Cornell Health.

Provider Name _____ Work Phone _____

Address _____
Street

_____
City *State* *Zip or Postal Code* *Country*

I have reviewed this Sports Clearance Form, and:

☐ I recommend that the patient be cleared for full participation in intercollegiate sports.

☐ I recommend that the patient be cleared for participation in intercollegiate sports with the following limitations: _____

_____

_____

_____

☐ I do not recommend this patient be cleared for participation in intercollegiate sports due to the following: _____

_____

_____

_____

Provider Signature _____ **Date** _____

K. STUDENT ATHLETE AGREEMENT AND SIGNATURE

- I understand that failure to have all appropriate medical records sent to Cornell Health will result in a delay of my sports clearance.

  ALL REQUIRED DOCUMENTATION (*as indicated by ✸ throughout this form*) must be mailed or faxed to:
  Cornell Health (Attn: Sports Medicine) Fax: 607.255.7786
  110 Ho Plaza Ithaca, NY 14853-3101 Phone: 607.255.5156

- I understand that I must refrain from practice or play during medical treatment until I am discharged from treatment, or am given permission by a Cornell Health clinician to resume participation despite continuing treatment.
- I understand that passing the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me at the time of the examination.
- I understand that even a normal history and examination does not preclude the existence of potentially life-threatening health problems.

I verify by my signature below that all information is current and accurate.

Student name (*please print*) _____

Student signature _____ **Date** _____

L. STUDENT ATHLETE AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Background information

The Health Insurance Portability and Accountability Act of 1996, requires that we guard the privacy of your protected health information. You have a right to confidential treatment of all information and records pertaining to your care. If you sustain an injury or have a condition or illness that might be affected by or interfere with your participation in intercollegiate athletics at Cornell University, it is important to understand that we may need to discuss your injury, condition or illness with your coaches, parents, and/or other people involved in your care.

Authorization

- I hereby authorize the certified athletic training staff, team physicians, and Cornell Health providers to disclose my personal health information for the following purposes:
  1. To discuss my injury/illness and treatments in relation to athletic participation with coaching staff, athletic training staff and other athletic staff so that they may make decisions regarding my ability to compete in athletics.
  2. To discuss my injury/illness and treatments in relation to athletic participation with my parent(s) and /or guardian(s) provided,; however, at any time I am able to revoke this part of the authorization by providing written notices to the athletic trainer providing my care and the health records manager at Cornell Health.
  3. To discuss my injury/illness and treatments with community specialists to whom I may be referred for further evaluation.
  4. In certain circumstances, to advise the media sideline reporters asking for injury updates; however, at any time I am able to revoke this part of the authorization by providing written notices to the athletic trainer providing my care and to the team coach.
- I understand that this authorization will expire upon exhaustion of athletic eligibility under NCAA rules.
- To protect my privacy, I understand that only the minimum amount of health information necessary will be released.
- I understand that refusing to sign this authorization or revoking this authorization (with the exception of the limited revocation referred to in #2 and #4 above) means my clearance to participate in my sport(s) may be withdrawn.
- I understand that my provider may not refuse to treat me if I refuse to sign this authorization.
- I understand that certain entities that receive health information may not be considered health care providers or health plans covered by federal privacy regulation, and that the information disclosed to such an entity may no longer be protected by the federal privacy regulation.

By signing this form I agree and understand the terms of this student athlete authorization.

Student name (*please print*) _____

Student signature _____ **Date** _____

ImPACT Concussion Baseline Test

INSTRUCTIONS

The ImPACT Concussion Baseline Test is a test of cognitive function including memory and reaction time. It is NOT a measure of intelligence! The purpose of the test is to have this information available for comparison in the event that you have a head injury or concussion during your season. It is a valuable tool for supporting the recovery of athletes after such an injury.

You must take the ImPACT test before coming to campus.

1. When should I take the test?

- The ImPact Test must be completed *prior* to your sports clearance at Cornell Health.
- We recommend that you do it as soon as possible.

2. What are the computer requirements for taking the test?

Check your computer carefully before you take the test. If the computer you use does not adhere to these requirements, your results will not be accurate, and you will need to repeat the test.

- **Mouse**: The computer you use MUST have an external mouse. Test results will not be accurate using a TouchPad or TrackPoint mouse. Most students who take the test without an external mouse score poorly on reaction time and have to repeat the test.
- **Power**: If you are taking your exam on a laptop computer, make sure it is plugged into an electrical outlet and is not running on battery power.
- **Internet**: Broadband internet connection *only*.
- **Browser**: Internet Explorer 6.0 and above, OR Firefox 1.5 or above, OR Safari for the Mac running OSX 10.2 and above.
- **Macromedia**: Adobe Flash Player 8.0 or newer. You can download Flash Player at *www.adobe.com*.
- **Pop-up blocker**: must be turned off for the duration of the test.
- **All other programs** on your computer must be closed before taking the test.

3. How long will the test take?

The test will take approximately 25 to 30 minutes. The system allows users up to 45 minutes to take the test.

4. How do I get started?

- **Preparation**: To ensure acceptable results, give this test your full attention. Go to a quiet place where you will be uninterrupted. Turn off cell phones, music, TV, and eliminate other background noises and distractions. Take the test when you are well-rested; taking the test when you are tired or distracted may interfere with your ability to answer clearly.
- **Log on**: Go to **www.impacttestonline.com/colleges**. Select "New York" when prompted to enter your organization. Then, click on "Launch Baseline Test." You will be prompted to enter your "Customer ID Code."
  Enter: C913B27570.
- **Identification:** Use your given name (no nicknames).
- **Initial questions**: You will be asked a series of background questions before taking the test. Please answer all of the questions as honestly as possible.
- **Test instructions**: Follow all instructions carefully. Missing key instructions or not giving the test your full attention will affect your results. Having accurate baseline information will be very important in assessing and supporting your recovery in the event of a head injury or concussion.
- **Put in your best effor**t. Be as quick and accurate as possible, as the tests measure both memory and reaction time. This is a hard test. No one gets everything right, so don't get frustrated. Your results will be reviewed and the test will be repeated if your results are not consistent. No one fails the test, but we strive to get a representative baseline for comparison should you have a head injury. If a third test is required, this will be done as a monitored test once you are on campus.

5. What do I do after I complete the test?

If you have completed the test, you do not need to do anything further.
If you have any questions or problems regarding the test or if you were unable to complete the test, please notify your coach, athletic trainer, or Cornell Health Sports Medicine staff at 607.255.5156.