CornellHealth

# Sports Clearance Process INSTRUCTIONS and FORM

## Your Sports Medicine team

Welcome student athletes participating in NCAA intercollegiate sports. The Sports Medicine team at Cornell Health specializes in sports clearance, sports injuries, and other injuries and illnesses that affect Cornell's intercollegiate athletes. We work closely with coaches, athletic trainers, nutritionists, and team orthopedists to help keep student athletes healthy and performing at their peak.

## The sports clearance process and deadlines

Cornell requires *every* athlete to receive a formal medical clearance each year. Follow these instructions thoroughly to complete your requirements by the deadline. You will not be able to participate with your team until you complete this process.

**DEADLINES:** **Fall 2018 entrants: June 15** **Spring 2019 entrants: December 20**
**Fall 2018 transfer students: July 31**

## Requirements

**You must complete:**

1. All of your New Student Health Requirements (*health.cornell.edu/requirements*)
2. ImPACT Concussion Baseline Test (page 3): online test that you must do before coming to campus
3. Sports Clearance Form (pages 4-7): requires input from both you and your health care provider

## Schedule an appointment with your health care provider

**You must obtain:**

1. **Verification of immunizations and TB screening test, if required** (unless you submit official school or military records)
2. **For the Physical Exam:**
   - ☐ Completed Physical Exam form, documenting an exam conducted after March 1, 2018. We will not accept substitute office notes or other exam forms.
   - ☐ Must include visual acuity, vital signs, and a copy of actual lab test result for Sickle Cell Trait.
   - ☐ Must include health care provider contact information and signature.
   - ☐ 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.

   *PLEASE NOTE:* If you do not provide the completed and signed Physical Exam 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. **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 her/his recommendations regarding your participation in intercollegiate sports.
   - ☐ Relevant chart (including surgery) notes and lab, Xray, CT, MRI, and DEXA scan reports.
   - ☐ Cardiology screening documents. *PLEASE NOTE:* 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).
4. **For student athletes on medication for ADD/ADHD:**

   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.
   - ☐ The ADHD/ADD Medical Exception Form must be completed by your health care provider and submitted with your Sports Clearance Form. Download the form and instructions from our website: *health.cornell.edu* [search: sports clearance].

## Submit all required materials

**Upload all required materials through myCornellHealth at *mycornellhealth.health.cornell.edu*:**

- Physical Examination Form *and* Sports Clearance Form *and* supporting documentation (also ADHD Medical Exception Form, if required)
  - Log in with Cornell net ID, password, and date of birth.
  - From Home Screen, click on "Messages."
  - Then "New message;" then "Send message or attachment to Health Records."
- Immunizations and TB Screening History:
  - Log in with Cornell net ID, password, and date of birth.
  - Select "Immunization Record" from the menu and choose "Add Immunization Record"
- If you are unable to upload records, you may *either* fax them to 607-255-0269, or mail them to:
  CORNELL HEALTH
  ATTN: Health Records Department
  110 Ho Plaza
  Ithaca, NY 14853-3101

## Next steps

1. **Check *myCornellHealth.***
   After you complete all of your 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 your new Cornell email address** and direct you to *myCornellHealth*. (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**.

2. **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.

3. **Once on campus, you will meet with an athletic trainer to complete the SCAT 3 Neuropsych exam**.
   This meeting will be scheduled after you arrive at Cornell and is a required part of the medical clearance process.

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 at 607.255.5156 (search "Sports Medicine" at *health.cornell.edu*).

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## Who should participate in the Sports Clearance Process

CLUB SPORTS PARTICIPANTS do not participate in the sports clearance process.
The Sports Clearance Process is required for students who will be participating in INTERCOLLEGIATE / NCAA SPORTS TEAMS:

| WOMEN'S SPORTS | | MEN'S SPORTS | |
|---|---|---|---|
| Basketball | Rowing | Baseball | Rowing - Heavyweight |
| Cross Country | Sailing | Basketball | Rowing - Lightweight |
| Equestrian | Soccer | Cross Country | Soccer |
| Fencing | Softball | Football | Sprint Football |
| Field Hockey | Squash | Golf | Squash |
| Gymnastics | Swimming & Diving | Ice Hockey | Swimming & Diving |
| Ice Hockey | Tennis | Lacrosse | Tennis |
| Lacrosse | Track & Field | Polo | Track & Field |
| Polo | Volleyball | | Wrestling |

CornellHealth

# 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.

## 1. When should I take the test?

- All entering intercollegiate athletes must complete the ImPACT test *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?

Please note that if the computer you use does not adhere to these requirements, your results may not be accurate, and you will need to repeat the test.

- **You must use an external mouse to take this test; do not use a laptop touchpad.**
- Your computer screen must be 12 inches or larger.
- You need a broadband Internet connection.
- Make sure you are using either the current version or the immediately previous version of your browser (Internet Explorer, Firefox, Chrome, or Safari).
- You must have Adobe Flash Player 11.0 or newer installed. You can download Flash Player at *adobe.com*.
- If you have a pop-up blocker installed, you must turn it off for the duration of the test.
- Your browser must accept cookies.
- JavaScript must be enabled in your browser.
- If you are running Windows 7, make sure power management is set to High Performance; otherwise performance may be slowed, negating test scoring.
- Close all other programs on your computer before taking the test.

## 3. How long will the test take?

The test takes 25-30 minutes for most students, although the system allows users up to 45 minutes for completion.

## 4. How do I get started?

- **Preparation**: To ensure the most accurate results, give this test your full attention. Turn off cell phones, music, and TV, and eliminate other background noises and distractions. Take the test when you are well-rested. Attempting to take the test when you are tired or distracted may interfere with the results.
- **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 directed to a series of 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?

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

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

# SPORTS CLEARANCE FORM

Today's Date _____ Name _____

Sport(s) _____ Cornell net ID _____

Address _____ Date of Birth _____

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 _____

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**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? _____ | ☐ | ☐ |
| 18. If yes, are you taking any medications? (list) _____ | ☐ | ☐ |
| 19. Do you have a history of bleeding disorders such as hemophilia, Von Willebrand disease or other factor deficiencies? | ☐ | ☐ |
| 20. ✸ If yes, provide documentation. _____ | | |
| 21. Have you ever been diagnosed with ADD/ADHD? _____ | ☐ | ☐ |
| 22. If yes, are you taking any medications? (list) _____ | ☐ | ☐ |
| 23. 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)? | ☐ | ☐ |

**Student Name** (*please print*)_____

## 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.
- 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 my understanding of these items, and that the information I have provided is current and accurate.

**Student signature** _____ **Date** _____

**Student Name** (*please print*)_____

## 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.

I verify by my signature that I understand and agree with the terms of this student athlete authorization.

**Student signature** _____ **Date** _____