CornellHealth

2024-25 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 2024 entrants: June 12** **Spring 2025 entrants: December 20**
Fall 2024 transfer students: July 25

Requirements

You must complete:

- ☐ All of your Health Requirements <health.cornell.edu/requirements>: complete your Medical Clearance list at myCornellHealth
- ☐ ImPACT Concussion Baseline Test (page 3): online test that you must do before coming to campus
- ☐ Sports Clearance Form (pages 4-7): needs to be completed by 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 Cornell Health Physical Examination Form, documenting an exam conducted after March 1, 2024 for fall entrants (August 1, 2024 for spring entrants). We will not accept other physical 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:**
   - ☐ 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. Download the form from health.cornell.edu [search: sports clearance].

Submit all required materials

Upload all documents through your Medical Clearance list:

- ☐ Use the "Athlete (NCAA) Physical Examination" item to upload your Physical Examination form.
- ☐ Use the "Athlete (NCAA) Sports Clearance" item to upload your Sports Clearance form.
- ☐ Use "Athlete: Doc. Upload" to submit test results (including your Sickle Cell Trait lab report) and other supporting documentation.
- ☐ If you are required to submit the ADHD/ADD Medical Exception Form, use "Athlete: Doc. Upload."

Uploads: We accept the following file types: PDF, PNG, JPG, JPEG, GIF, PDF (no larger than 4 MB).
If any document is more than one page, please upload as a single, multi-page attachment.

If you are not able to upload through your Medical Clearance list, please:

- FAX: 607.255.0269, OR
- Mail: Cornell Health Attn: Requirements Office, 110 Ho Plaza, Ithaca, NY 14853-3101
- Do not email, because email is not a secure way to transmit personal health information.

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. If you hear from us, **please read your secure message promptly**.

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 6 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 athletic trainer or contact the Sports Medicine team at 607.255.5156 [search "Sports Medicine" at health.cornell.edu].

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

Basketball
Cross Country
Equestrian
Fencing
Field Hockey
Gymnastics
Ice Hockey
Lacrosse
Polo
Rowing
Sailing
Soccer
Softball
Squash
Swimming & Diving
Tennis
Track & Field
Volleyball

MEN'S SPORTS

Baseball
Basketball
Cross Country
Football
Golf
Ice Hockey
Lacrosse
Polo
Rowing - Heavyweight
Rowing - Lightweight
Soccer
Sprint Football
Squash
Swimming & Diving
Tennis
Track & Field
Wrestling

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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 technical requirements for taking the test?

You will take the test using your own computer. Please make sure you have a good internet connection, and a private and quiet location to take the test.

3. 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. Please be sure to choose the correct mouse type (external mouse or laptop touchpad).
- **Log on**: **Go to impacttestonline.com/colleges:**
    - **Select "New York" when prompted to enter your organization**
    - **Click on "Launch Baseline Test"**
    - **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 effort**. 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.

4. 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.

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.

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Sports Clearance Form

Today's date ____________ Student 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			APPROX DATE
	None	Old	Current	
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 PAGE 3.

C. NEUROLOGICAL ISSUES

	Yes	No
1. Have you ever had a head injury or concussion? ____________	☐	☐
If yes, how many? ____________		
List the dates of the last 3 concussions you have sustained (mm/yyyy): ____________		
With any of the concussions you sustained, did you experience:		
Any loss of consciousness? ____________	☐	☐
Any memory loss? ____________	☐	☐
Any symptoms lasting longer than 10 days? ____________	☐	☐
If yes, list the 3 main symptoms: ____________		
2. Have you ever had a seizure (e.g. epilepsy)? If yes, date of last seizure ____________	☐	☐
List all current medications you take to prevent seizures ____________		
3. Do you have frequent or severe headaches? ____________	☐	☐
Date last evaluated by health care provider ____________		
List all headache medications that you take ____________		
4. Do you have headaches with exercise? ____________	☐	☐
5. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ____________	☐	☐
6. Have you ever been unable to move your arms or legs after being hit or falling? ____________	☐	☐
7. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ____________	☐	☐

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? ____________	☐	☐

Student Name (please print)____

EXPLAIN ALL "YES" ANSWERS IN SECTION I ON PAGE 3.

E. GENERAL HEALTH ISSUES

#	Question	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)? If yes, when (mm/yyyy)? ______	☐	☐
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 have a history of bleeding disorders such as hemophilia, Von Willebrand disease or other factor deficiencies? ✸ If yes, provide documentation. ______	☐	☐
18.	Have you ever been diagnosed with ADD/ADHD? ______ If yes, are you taking any medications? (list) ______	☐	☐
19.	Do you have any current mental health concerns (e.g., depression, anxiety, stress, insomnia)? If yes, please describe. ______	☐	☐
20.	Are you currently being treated for any mental health concerns or have a history of treatment for any mental health concerns? If yes, please describe. ______ Are you taking medication for these concerns? (list) ______	☐	☐
21.	Have you had any medical or mental health problem(s) that kept you from participating in your sport for a period of time? If yes, please describe. ______	☐	☐
22.	Do you have any other ongoing health problems for which you are being treated (e.g. anemia, asthma, diabetes, eating issues, thyroid disorder, etc.)? If yes, please list. ______	☐ ☐	☐ ☐
23.	Are you vaccinated against COVID-19? Please upload documentation at dailycheck.cornell.edu. ______	☐	☐
24.	Have you ever been diagnosed with COVID-19? If yes, please include date(s). ______	☐	☐
25.	If you have had COVID-19, do you experience persistent symptoms? If yes, please list. ______	☐	☐

F. CARDIOLOGY SCREENING

✸ For all YES answers, you must provide copies of chart notes or test reports.

#	Question	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. ENERGY BALANCE

#	Question	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/lose weight or improve your performance? ______	☐	☐
6.	Have you ever had a stress fracture? ______	☐	☐
7.	Have you ever been told you have low bone density (osteopenia or osteoporosis)? ______	☐	☐

H. WOMEN'S HEALTH (Students assigned female at birth)

#	Question	Yes	No
1.	Have you ever had a menstrual period?______	☐	☐
2.	How old were you when you had your first menstrual period? ______		
3.	Do you get your menstrual period regularly? ______	☐	☐
a.	If yes, what was the date of your last menstrual period?______		
b.	If no, is it due to taking birth control?______	☐	☐
4.	Are you presently taking any female hormones (estrogen, progesterone, birth control)?______	☐	☐
a.	If yes, please describe:______		

Student Name (please print)____

I. PROVIDE AN EXPLANATION HERE FOR ALL "YES" ANSWERS (in sections C through H).

____

____

____

____

____

____

____

____

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 health 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.
  5. To discuss my injury/illness and treatments with Cornell University's Crisis Management staff should I experience a crisis (immediate threat to life, health, property, or environment), OR if a crisis manager has been assigned to support, work, and follow up with me.
  6. I allow athletic training staff, team physicians, and Sports Medicine staff to utilize text messaging and/or email to communicate with me, or about me with others involved in my care or treatment. I understand that only the minimum necessary information will be shared. I further understand and have been warned that text messaging and/or email is not secure and that the risk of unauthorized disclosure exists. I understand that I am able to revoke this part of the authorization by providing written notices to the athletic trainer providing my care and to Cornell Health's Privacy Officer.
- 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, #4, and #6 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** ____________________