



Cornell University Gannett Health Services

Sports Medicine
Gannett Health Services
Ithaca, NY 14853-3101
t. 607.255.5155
f. 607.255.0269
www.gannett.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, 2016; 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:

Gannett Health Services (Attn: Sports Medicine) Phone: 607.255.5155
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 Gannett Health Services. 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 17 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: <http://www.gannett.cornell.edu/services/medical/sports/clearance.cfm>

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 *myGannett*.**

After you complete all of these requirements, the Gannett 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 *myGannett*.

This secure web portal facilitates confidential and timely communication between Gannett and those who use our services. You can get to it from any page on the Gannett Health Services website: www.gannett.cornell.edu. When you receive an email directing you to *myGannett*, **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 Gannett. 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 Gannett on the day of your team's Sports Clearance. If you are *not* pre-cleared, you must report to Gannett 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 (visit www.gannett.cornell.edu and search "Sports Medicine Team").

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

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

CLUB SPORTS PARTICIPANTS do not participate in the sports clearance process.

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

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 _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hit in the head and been confused or lost your memory? _____ If yes, describe _____	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have frequent or severe headaches? _____ Date last evaluated by health care provider _____ List all headache medications that you take _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have headaches with exercise? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been unable to move your arms or legs after being hit or falling? _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? _____	<input type="checkbox"/>	<input type="checkbox"/>

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight for reasons other than surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

E. GENERAL MEDICAL ISSUES

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are there any current prescription medicines or over-the-counter medicines that you take regularly? (list) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any allergies to medicines? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any severe allergies to food or insect stings? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have seasonal allergies (hay fever) or other allergies that require medicines? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had any rash or hives develop during or after exercise? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you cough, wheeze, or have breathing difficulty during or after exercise? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have asthma? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever used an inhaler, or taken asthma medicine? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is there anyone in your family who has asthma? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have any current skin problems (e.g. athlete's foot, ringworm, impetigo)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had a herpes skin infection? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had infectious mononucleosis (mono) within the past month? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. When exercising in the heat, do you have severe muscle cramps or become ill? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had a detached retina or any severe eye trauma? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Is your vision in either eye worse than 20/40 even with correction (contacts or glasses)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you feel significantly stressed or depressed? _____
If yes, are you taking any medications? (list) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have a history of bleeding disorders such as hemophilia, Von Willebrand disease or other factor deficiencies?
★ If yes, provide documentation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever been diagnosed with ADD/ADHD? _____
If yes, are you taking any medications? (list) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have any other ongoing medical problems for which you are being treated (e.g. anemia, asthma, diabetes, thyroid disorder, etc.)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

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. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had discomfort, pain or pressure in your chest during exercise? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does your heart race or skip beats during exercise? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has a doctor ever told you that you have any of the following? If yes, please check all that apply:
<input type="checkbox"/> high blood pressure <input type="checkbox"/> heart murmur <input type="checkbox"/> high cholesterol <input type="checkbox"/> heart infection | | |
| 5. Has a doctor ever ordered a test for your heart? (e.g. ECG, echocardiogram) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has anyone in your family died for no apparent reason? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has any family member/relative died of heart problems or sudden death before age 50? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has a physician ever denied or restricted your participation in sports for any heart problems? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is there any family history of Marfan's Syndrome, cardiomyopathy or long QT syndrome, or other heart problem? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

G. WOMEN'S HEALTH (Females only.)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you worry about your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you trying to, or has anyone recommended that you gain or lose weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you on a special diet, or do you avoid certain types of food? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever taken any supplements to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been told you have low bone density (osteopenia or osteoporosis)? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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.

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 Gannett will result in a delay of my sports clearance.

ALL REQUIRED DOCUMENTATION (*as indicated by ★ throughout this form*) must be mailed or faxed to:

Gannett Health Services 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 Gannett Health Services 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 Gannett Health Service 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 Gannett Health Services Health Information Manager.
 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 Gannett Health Services.
- 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 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. 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 Gannett Sports Medicine staff at 607.255.5155.