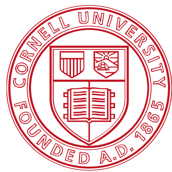

Cornell University
Gannett Health Services

Gannett Health Services
Sports Medicine
Ithaca, NY 14853-3101
t. 607.255.5155
f. 607 255.7786
web: www.gannett.cornell.edu

Sports Clearance Form Instructions

To protect the health of Cornell's intercollegiate student athletes, the University requires every athlete to receive a formal medical clearance *each year* from Gannett Health Services Sports Medicine department. Since this is your first time, it is especially important that you follow the instructions below *thoroughly* to ensure a timely clearance process. You will not be able to participate on your team until you complete this process.

- Fill in the attached Sports Clearance Form as completely as possible. Then, take it and your Health History Form to your health care provider for documentation of a physical examination conducted after January 1, 2009.
  - **For all "yes" answers on the Sports Clearance Form**: Please explain in detail in space provided. If your injury/ surgery/illness is within the past year, you must have chart notes, surgery notes, lab reports, x-ray reports and a return to play note mailed or faxed to Gannett Sports Medicine (*contact information below*).
  - **For "yes" answers on questions 29 – 38**: You must have chart notes from your cardiologist or primary care provider addressing these answers sent to Gannett Sports Medicine. Include copies of EKG, echocardiogram, stress echo, or other reports. If you have seen a cardiologist, please include his/her recommendations regarding your participation in NCAA sports.
- Submit your Sports Clearance Form and Health History Form *together* by the deadline: **June 12 for summer/fall entrants**; August 1 for fall transfer students.
- Report to Gannett with your team at the scheduled time for your sports clearance after you come to Cornell. Your coach will have the schedule.

PLEASE NOTE: Failure to have appropriate medical records sent to Gannett will result in delay of your sports clearance.

  - If you have not had a physical exam and have not had your Sports Clearance Form reviewed by your health care provider, your sports clearance will be delayed. Charges for a physical exam done at Gannett Health Services will be your responsibility.
  - If there are significant abnormalities on your Sports Clearance Form or physical exam that have not been addressed by your health care provider, further evaluation may be necessary. Cost of consultation/diagnostic testing is not covered by Cornell Athletics and will be your responsibility.

SEND RECORDS TO:

Gannett Health Services
Attn: Sports Medicine
110 Ho Plaza
Ithaca, NY 14853-3101

Fax: 607.255.7786
Phone: 607.255.5155

GANNETT HEALTH SERVICES
110 Ho Plaza , Ithaca, New York 14853-3101
Phone: 607.255.5155 Fax: 607.255.0269

Sports Clearance Form

Today's Date ____________________ Name ______________________________

Sport(s) ______________________________ Cornell ID ____________________

Address ______________________________ DOB ____________________

E-mail Address ______________________________ Gannett Use Only: PCP ____________________

Home Phone ( ) ____________________ Cell Phone ( ) ____________________ MRN ____________________

Personal Physician ______________________________ Physician Phone & Fax __________ / __________

A. CHECK AND EXPLAIN IN THE SPACE PROVIDED BELOW, ALL PREVIOUS INJURIES.

– 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 have chart notes and radiology reports faxed to Gannett.

	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. LIST ALL SURGERIES AND APPROXIMATE DATES.

– If surgery was in the past year, please fax to Gannett a summary, copies of any surgical notes, and notes that cleared you to return to your sport.

Type of Surgery ______________________________ Date ____________
______________________________ Date ____________

◆ **For sections C and D, EXPLAIN ALL "YES" ANSWERS in the space provided on next page.** ◆

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

Continue on next page ⇨ ⇨

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☐ *Reviewed by Nurse (initial)* ____________________ *Date* ____________
☐ *Hold–Nurse visit only Initials/Date* ____________ *For:* ☐ *Td* ☐ *V.A.* ☐ *BP* ☐ *Asthma* ☐ Other ____________
☐ *Hold – Initials/Date* ____________ ❑ Temporary Clearance – Initials/Date ____________
☐ *Cleared – Rehab only – Initials/Date* ____________ ☐ *Cleared – Gannett Signature/Date* ____________

◆ EXPLAIN ALL "YES" ANSWERS in the space provided below. ◆

	Question	Yes	No
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 and x-ray for atlantoaxial (neck) instability?	☐	☐
9.	Are there any current prescription medicines or over-the-counter medicines that you take regularly? Please list below.	☐	☐
10.	Do you have any allergies to medicines?	☐	☐
11.	Do you have any severe allergies to food or insect stings?	☐	☐
12.	Do you have seasonal allergies (hay fever) or other allergies that require medicines?	☐	☐
13.	Have you ever had any rash or hives develop during or after exercise?	☐	☐
14.	Do you cough, wheeze, or have breathing difficulty during or after exercise?	☐	☐
15.	Do you have asthma?	☐	☐
16.	Have you ever used an inhaler, or taken asthma medicine?	☐	☐
17.	Is there anyone in your family who has asthma?	☐	☐
18.	Do you have any current skin problems (e.g. athletes foot, ringworm, impetigo)?	☐	☐
19.	Have you ever had a herpes skin infection?	☐	☐
20.	Have you had infectious mononucleosis (mono) within the past month?	☐	☐
21.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
22.	Has a doctor told you that you or some in your family has sickle cell trait or sickle cell disease?	☐	☐
23.	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)?	☐	☐
24.	Have you ever had a detached retina or any severe eye trauma?	☐	☐
25.	Is your vision in either eye worse than 20/40 even with correction (contacts or glasses)?	☐	☐
26.	Do you feel significantly stressed or depressed?	☐	☐
	If yes, are you taking any medications? (list)	☐	☐
27.	Has anyone recommended you change your weight or eating habits?	☐	☐
28.	Do you have any history of anorexia or bulimia?	☐	☐

Questions 29–38. For any YES answers, please fax copies of chart notes or test reports to Gannett.

	Question	Yes	No
29.	Have you ever passed out, or nearly passed out, during or after exercise? (If yes, list dates)	☐	☐
30.	Have you ever had discomfort, pain or pressure in your chest during exercise?	☐	☐
31.	Does your heart race or skip beats during exercise?	☐	☐
32.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection	☐	☐
33.	Has a doctor ever ordered a test for your heart? (e.g. ECG, echocardiogram)	☐	☐
34.	Has anyone in your family died for no apparent reason?	☐	☐
35.	Has any family member/relative died of heart problems or sudden death before age 50?	☐	☐
36.	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
37.	Is there any family history of Marfan's Syndrome, cardiomyopathy or long QT syndrome, or other heart problem?	☐	☐
38.	Do you have any ongoing medical problems for which you are being treated (e.g. anemia, diabetes, thyroid disorder, asthma, etc.)?	☐	☐

Females Only:

39. At what age was your first menstrual period? ______________
40. How much time do you usually have from the start of one period to the start of another? ______________
41. What was the longest time between periods in the past 12 months? ______________
42. Do you use an oral or injectable form of contraception, or other hormonal medication? ______________ ☐ Yes ☐ No

◆ EXPLAIN ALL "YES" ANSWERS HERE for questions in Sections C (1–3) and D (1–42). ◆

Student Name (*please print*) ______________________________

Continue on next page ⇨ ⇨

E. HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

- This section must be completed by your health care provider from home.
- Health care provider contact information and signature is required for completion of this form.
- The final sports clearance decision will be made by the Cornell University Chief of Sports Medicine or designee.

Provider Name ______________________________ Work Phone ____________________

Address ____
Street

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

I have reviewed this Sports Clearance Form.

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

☐ I recommend that the patient be cleared for participation in NCAA sports with the following limitations: ____________________
____

☐ I do not recommend this patient be cleared for participation in NCAA sports due to the following: ____________________
____
____
____

Provider Signature ______________________________ Date ____________________

F. 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 RECORDS related to sections A, B, and D should be mailed or faxed to:
  Gannett Health Services Fax: 607.255.7786
  Attn: Sports Medicine Phone: 607.255.5155
  110 Ho Plaza
  Ithaca, NY 14853-3101
- 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.
- I understand that Gannett Health Services Sports Medicine may need to communicate medical or mental health information to my athletic trainer if my condition will affect my ability to practice or compete in my sport. Information will be the minimum necessary to assist in making decisions regarding my participation, athletic treatment, and rehabilitation. I understand that I may revoke this consent at any time with the knowledge that my clearance to participate in my sport(s) may be withdrawn. I also understand that while it is Cornell's general practice to disclose such information only as appropriate in relation to my continued participation in athletics, re-disclosure by the recipient (e.g., to my coach and others as may be necessary or appropriate) is no longer protected under the medical privacy law (HIPAA).

Student name (*please print*) ______________________________

Student signature ______________________________ Date ____________________

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Nursing Notes ____
____
____

Sports Clearance Clinical Notes ____
____
____
____
____
____
____

Gannett health care provider signature ______________________________ *Date* ____________________