SKIDMORE STUDENT ATHLETE PAPERWORK

1st Year Student Athlete Requirements

- All students participating in Skidmore NCAA athletics for the first time must complete all 4 documents attached, as listed below.
- Deadline: July 15, 2024
- Please upload completed documents to the Health Services Portal: (https://skidmore.studenthealthportal.com)

Form Required	Completed by:	Completed	Uploaded to portal
Part 1: Sports Health History Form	Student and medical provider	☐	☐
Part 2: Physical Exam Form completed on or after 3/1/24	Medical provider	☐	☐
Part 3: Sickle Cell Test Results	Medical provider (lab result)	☐	☐
Part 4: Release of information with Athletic Trainers	Student	☐	☐

* Physical Exam Form can be used for incoming student & athletic participation requirements as long as on or after March 1, 2024.
* Alternative physical exam documentation, such as a standard PCP form, may be accepted but *must* include:
    1. Clear documentation of full physical exam with any pertinent clinical findings
    2. Signed statement from a medical provider that you can "participate in athletics without restriction."

Upload by July 15, 2024

SKIDMORE COLLEGE HEALTH SERVICES

Phone: 518-580-5550 Fax: 518-580-5556 E-mail: health@skidmore.edu

PART 1: SPORTS HEALTH HISTORY FORM

Student athlete must complete form prior to seeing medical provider.
Medical provider must review and sign form prior to submission. Thank you!

Last Name ______________________ First Name ______________________ Date of birth ____________
Class Year____________________ Sport(s):______________________________

Medicines and Allergies: Please list all of the prescription, over-the-counter medicines and supplements you are currently taking including doses.

____
____
____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Food ☐ Other (please specify)

Explain "Yes" answers below. Circle anything you don't know the answer to.

GENERAL QUESTIONS	Yes	No
1. Has a medical provider ever denied or restricted your participation in sports for any reason?		
2. Have you ever had an illness or injury that caused you to miss more than 3 days of practice or competition?		
3. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:		
4. Have you ever spent the night in the hospital?		
5. Have you ever had surgery? If yes, please list below.		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
6. Have you ever passed out or nearly passed out during or after exercise?		
7. Do you ever get lightheaded, feel short of breath or feel more tired than expected during exercise?		
8. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
9. Does your heart ever race or skip beats during exercise?		
10. Has a medical provider ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ Heart murmur ☐ Heart infection ☐ High cholesterol ☐ Heart abnormality ☐ Cardiomyopathy ☐ Other:		
11. Has a medical provider ever ordered a test for your heart? (i.e. EKG, echocardiogram)		
12. Have you ever been restricted or denied participation in sports due to heart problems?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any relative died of heart problems or died unexpectedly before age 50?		
14. Does anyone in your family have hypertrophic cardiomyopathy or Marfan syndrome?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		

BONES AND JOINTS	Yes	No
16. Do you have any recent or ongoing problems with a bone, joint, ligament or muscle?		
COVID-19	Yes	No
17. Have you ever had COVID-19? If yes, date:		
Have your symptoms prevented you from returning to your regular activity level?		
Has a medical provider restricted your return to sports?		
HEAD INJURY/CONCUSSIONS	Yes	No
18. Have you ever had a head injury or concussion? If yes, please specify how many, date of injury, and the severity in comments below.		
MEDICAL QUESTIONS	Yes	No
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
20. Were you born without or are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
21. Have you had infectious mononucleosis (mono) within the last month?		
22. Do you have any rashes or other skin problems?		
23. Have you ever had a seizure or do you have a history of a seizure disorder?		
24. Do you have frequent or severe headaches or migraines?		
25. Have you ever been unable to move your arms or legs or had numbness, tingling or weakness in your arms or legs after being hit or falling?		
26. Have you had problems with your eyes or vision, including any eye injuries?		
27. Do you wear any protective gear or corrective devices? ☐ Glasses or contacts ☐ Joint braces ☐ Hearing aids ☐ Other:		
28. Have you skipped a period(s) in the past year? ☐ Not applicable		
29. Do you worry about your weight?		
30. Are you trying to, or has anyone recommended that you, gain or lose weight?		
31. Have you ever had disordered eating?		
32. Do you have any concerns that you would like to discuss with a medical provider?		

Explain "Yes" answers: ____
____
____

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.

Athlete signature__________________ Parent/Guardian if under 18__________________ Date__________

TO BE COMPLETED BY PHYSICIAN OR ADVANCED PRACTICE CLINICIAN

☐ I have reviewed the above health history and there are no findings that prohibit participation in competitive athletics or warrant additional work-up.
☐ Athlete is not cleared for participation and requires further work-up.
Notes:____
____

Provider signature__________________ Printed name, title __________________ Date__________

PART 2: PHYSICAL EXAM FORM

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	Date of Birth:
VITAL SIGNS:	Ht:	Wt:	B/P:	Pulse:	

MEDICATIONS:	ALLERGIES:

PAST MEDICAL HISTORY:				
Item/Area Evaluated	Normal	Not Examined	Abnormal	If Abnormalities Are Noted, Please Describe
Appearance				
Nose & Sinuses				
Mouth & Throat				
Teeth & Gingiva				
Ears				
Eyes				
Neck				
Lungs				
Heart				
Vascular				
Abdomen				
Genitalia				
Upper Extremities				
Lower Extremities				
Spine				
Neurologic				

SPORTS CLEARANCE FOR NCAA ATHLETES:

☐ I have examined this patient within the past 6 months (ON or AFTER 3/1/2024 per NCAA requirements)

☐ Cleared for all sports without restriction (*Note: Sports Health History For must also be reviewed and signed by provider)

☐ Cleared after completing evaluation/rehabilitation for:

____

☐ Not cleared for:

____

____

Additional recommendations/comments:

____

____

PROVIDER INFORMATION & SIGNATURE REQUIRED

For general college participation, I have examined this patient within the past 2 years (AFTER 7/5/2022). All medical/psychiatric conditions and therapies are noted above or on attached pages.

Date of Exam: ____/_____ /_____

Print Provider Name:

Address (Please print or stamp):

Phone # (_____) ___________ Fax # (_____) ___________

____________________________________ ____________

Signature of Healthcare Provider Degree

updated 4/2024

PART 3: SICKLE CELL TEST RESULTS

Effective August 1, 2022 the NCAA requires that all Division III student-athletes provide *proof* of sickle cell testing.

To meet requirements students must submit results for ONE of the following:

- Hemoglobin Solubility or Hemoglobin S test
- Sickle Cell Solubility Test
- Hemoglobinopathy panel that includes hemoglobin A +/- hemoglobin F, S.
- Newborn screening results. The panel must specify "hemoglobinopathy screen" or "sickle cell screen." In 2000, 41 states required sickle cell testing as part of newborn screening testing done for all born in a hospital setting. As of 2006 it is universally required.

Submit by: Uploading through the Health Services Portal (https://skidmore.studenthealthportal.com).
Be sure the screenshot, results or document includes your name and date of birth

If you are unable to have testing or results prior to arriving on campus you can schedule an appointment with Skidmore College Health Services and pay an out-of-pocket fee of $7 for the testing (cost subject to change at any time).
** Note: This may delay the start to your season depending on the timing. **

About Sickle Cell Trait

- Sickle Cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Sickle Cell trait is a common condition (>3 million Americans)
- Although Sickle Cell trait is most predominant in those of African, Mediterranean, Middle Eastern, Indian, Caribbean, as well as South and Central American descent, persons of all races, sex, and descent may test positive for sickle cell trait.
- Sickle Cell trait is usually benign but can be life-threatening especially during intense, sustained exercise. It causes some red blood cells to change from a normal disc shape to a crescent or "sickle" shape which do not move through blood vessels smoothly. Eventually blood flow (and therefore oxygen) to muscles can be blocked. When muscles lack oxygen, they break down and an accumulation of the products of the break-down can lead to rhabdomyolysis (a condition that can cause collapse of vital organs such as the heart and kidneys). For more information on Sickle cell trait: http://fs.ncaa.org/Docs/health_safety/SickleCellTraitforSA.pdf

PART 4: RELEASE OF MEDICAL INFORMATION WITH ATHLETIC TRAINERS

This release is to enable Skidmore Health Services and Athletic Training staff to work collaboratively in medical care for athletes, especially pertaining to injuries or conditions affecting an athlete's ability to play/compete. Examples of conditions where it is important that such medical information is shared includes: concussions, musculoskeletal injuries, recent surgeries, heart conditions, asthma, COVID-19, certain prescription medications etc.

I, ____, authorize release of medical information (allergies, medications, medical diagnoses, injuries, medical/surgical/family history & immunizations) to Skidmore College athletic trainer and/or consulting medical providers. Release of this information will enable Health Services and athletic training staff members to work collaboratively.

☐ Yes ☐ No

Athlete signature______________________________________Date________________

Parent/Guardian (if under 18)_____________________________Date________________