



# SKIDMORE STUDENT ATHLETE PAPERWORK 2026-2027

## 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, 2026**
- You will need to upload completed documents to the new Health & Wellness Portal which will be available after May 11, 2026. Visit the Health Services Website (<https://www.skidmore.edu/health-services/index.php>) for further details at that time.

Requirement (forms included in this packet)	Completed by:	Completed	Uploaded to portal after 5/11/26
1. Sports Health History Form	Student and home medical provider	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical Exam Form completed on or after 3/1/26*	Home medical provider	<input type="checkbox"/>	<input type="checkbox"/>
3. Sickle Cell Test Results	Medical provider (lab result)	<input type="checkbox"/>	<input type="checkbox"/>
4. Release of information with Athletic Trainers	Student	<input type="checkbox"/>	<input type="checkbox"/>

\* Physical Exam Form can be used for incoming student & athletic participation requirements as long as on or after March 1, 2026 (for athletes beginning Fall 2026).

\* 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, 2026**

SKIDMORE COLLEGE HEALTH SERVICES

Phone: 518-580-5550 Fax: 518-580-5556 E-mail: [health@skidmore.edu](mailto:health@skidmore.edu)



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## SPORTS HEALTH HISTORY FORM

*Student athlete must complete form prior to seeing home medical provider.*

*Medical provider, who is not related to the student athlete, must review and sign form prior to submission. Thank you!*

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Class Year: \_\_\_\_\_

Sport(s): \_\_\_\_\_

**MEDICATIONS** – 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, identify specific allergy AND REACTION here:

**ANY "YES" ANSWERS REQUIRE EXPLANATION BELOW.** CIRCLE ANYTHING YOU DON'T KNOW THE ANSWER TO.

GENERAL QUESTIONS	Yes	No	BONES AND JOINTS	Yes	No
1. Has a medical provider ever denied or restricted your participation in sports for any reason?			16. Do you have any recent or ongoing problems with a bone, joint, ligament or muscle?		
2. Have you ever had surgery? If yes, please list below.			<b>HEAD INJURY/CONCUSSIONS</b>	Yes	No
3. Do you have any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other:			17. Have you ever had a head injury or concussion? If yes, please specify how many, date of injury, and the severity in comments below.		
4. Have you ever spent the night in the hospital?			<b>MEDICAL QUESTIONS</b>	Yes	No
5. Have you ever had an illness or injury that caused you to miss more than 3 days of practice or competition?			18. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	Yes	No	19. Do you have any rashes or other skin problems?		
6. Have you ever passed out or nearly passed out during or after exercise?			20. Have you had infectious mononucleosis (mono) within the last month?		
7. Do you ever get lightheaded, feel short of breath or feel more tired than expected during exercise?			21. Were you born without or are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
8. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?			22. Have you ever had a seizure or do you have a history of a seizure disorder?		
9. Does your heart ever race or skip beats during exercise?			23. Do you have frequent or severe headaches or migraines?		
10. Has a medical provider ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart infection <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart abnormality <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Heart arrhythmia <input type="checkbox"/> POTS <input type="checkbox"/> Other:			24. 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?		
11. Has a medical provider ever ordered a test for your heart? (i.e. EKG, echocardiogram)			25. Have you had problems with your eyes or vision, including any eye injuries?		
12. Have you ever been restricted or denied participation in sports due to heart problems?			26. Have you ever had disordered eating? If yes, please specify type, dates, treatment below.		
<b>HEART HEALTH QUESTIONS ABOUT BIOLOGICAL FAMILY</b>	Adopted	Yes	No	27. Are you trying to, or has anyone recommended that you, gain or lose weight?	
13. Has any relative died of heart problems or died unexpectedly before age 50?				28. Do you worry about your weight?	
14. Does anyone in your family have hypertrophic cardiomyopathy or Marfan syndrome?				29. Have you skipped a period(s) in the past year NOT related to medications (ex: IUD, birth control pill, Nexplanon, etc)? <input type="checkbox"/> Not applicable	
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				30. 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 Sig if under 18: \_\_\_\_\_ Date: \_\_\_\_\_

### TO BE COMPLETED BY HOME PHYSICIAN OR ADVANCED PRACTICE CLINICIAN (NOT A FAMILY MEMBER)

**CLEARED:** I have reviewed the above health history and there are no findings that prohibit participation in competitive athletics or warrant additional work-up.

**NOT CLEARED:** Athlete is not cleared for participation and requires further work-up.

Notes:

Provider signature: \_\_\_\_\_ Printed name, title \_\_\_\_\_ Date \_\_\_\_\_



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PHYSICAL EXAM FORM

LAST NAME: FIRST NAME: DATE OF BIRTH:

VITAL SIGNS: Ht: Wt: BP: Pulse:

PAST MEDICAL HISTORY (or attach EMR documentation):

Table with 5 columns: ITEM/AREA EVALUATED, NORMAL, NOT EXAMINED, ABNORMAL, IF ABNORMALITIES ARE NOTED, PLEASE DESCRIBE. Rows include Appearance, Nose & Sinuses, Mouth, Throat, Dentition, Ears, Eyes, Neck, Lungs, Heart, Vascular, Abdomen, Upper Extremities, Lower Extremities, Spine, Neurologic, Other (please specify).

MEDICAL PROVIDER ATTESTATION

FOR ALL INCOMING STUDENTS:

I have examined this patient within the past 2 years (AFTER 7/15/2024\*). All medical/psychiatric conditions and therapies are noted above or on attached pages.

\*FOR STUDENTS PARTICIPATING IN NCAA ATHLETICS EXAM MUST BE WITHIN 6 MONTHS OF PARTICIPATION (ON or AFTER 3/1/2026 for students joining team Fall 2026) per NCAA requirements

- Cleared for all sports without restriction based on physical exam (\*Note: Sports Health History Form must also be reviewed and signed by provider)
Cleared after completing evaluation/rehabilitation for:
Not cleared due to:

Additional recommendations/comments:

Provider Name (Print): Date of Exam:

Signature of Medical Provider: Provider credentials:

Provider Address, Phone Number, Fax number (Please print or stamp):

Phone # ( ) Fax # ( )



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# 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 and Wellness Portal (available May 11, 2026 – check Health Services website closer to date for specific instructions/links)

**\*\*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 \$11 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](http://fs.ncaa.org/Docs/health_safety/SickleCellTraitforSA.pdf)



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**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.

**CHECK ONE:**

Yes, I agree

No, do not share information

Athlete **signature\*** \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian\* (if under 18) \_\_\_\_\_ Date \_\_\_\_\_

**\*Must be signature/script. Typed signature will not be accepted.**