Dear Varsity Athlete:

Welcome and congratulations on your acceptance to Yale University. Yale Health provides every student athlete with a multidisciplinary, comprehensive, quality medical team trained in Sports Medicine. Our team consists of:

- primary care sports medicine doctors
- sports medicine orthopedic surgeons
- sports cardiologists
- nurse coordinator
- sport certified registered dietitian
- mental health providers
- physical therapists
- athletic trainers
- strength and conditioning coaches

We also work closely with Yale Medicine to access services of medical and surgical specialty care.

In order to compete in a Yale varsity athletic program you must complete and return the Intercollegiate Pre-participation Medical Evaluation form. The form must be completed, signed by your medical clinician and received by August 15, 2020.

All athletes undergo a comprehensive medical evaluation prior to participating in their respective sport. As part of this evaluation, we will ask you for details about your family medical history. Please review your family’s medical history with your parents, including any heart problems on either side of the family, and any instances of early heart failure, arrhythmia, or sudden death in relatives under 50 years old. Additionally, you will receive an electrocardiogram (also known as ECG or EKG) prior to sport participation.

Most ECGs are normal. However, approximately 1 in 15 athletes require further testing because of an abnormality on the ECG. Further testing may include: an echocardiogram (heart ultrasound); a heart monitor (24 hour holter), stress test, or MRI of the heart. Should further testing be required after comprehensive physical examination and ECG, you will be scheduled for the test at Yale. These tests will be performed in an expedited manner to minimize any disruption to your academic and athletic schedule. While subsequent testing is most often normal, occasionally we do find abnormalities that may put athletes at risk for participation in sports. In this rare event, our Sports Cardiology team will discuss your options, including special precautions, treatments, and safety for participating in sports.

Yale Health Athletic Medicine requires submission of a copy of the laboratory results of your Sickle Cell Trait test prior to athletic participation. In some states, this testing is done at birth, so you should check with your pediatrician’s office for this documentation. If no
documentation exists, then a Sickle Cell Trait test (either Hemoglobin Solubility or Sickle Cell Screen) MUST be performed prior to sport participation.

**You will not be permitted to participate in any varsity try-outs, practices or games until the completed Pre-participation Health Evaluation form, Sickle Cell Trait laboratory results, and other required documentation requested on the Intercollegiate Pre-Participation Health Evaluation is received.**

For female athletes we strongly recommend a **Ferritin** level and a **Complete Blood Count** (CBC) be provided. This can be obtained through a simple blood test ordered by your medical clinician. We recommend this due to the prevalence of anemia and low iron in the female athlete population.

You **do not** need to complete this form if you plan to participate in club or intramural programs (e.g., Rugby, Water Polo, Wrestling, Equestrian, Ultimate Frisbee, etc.), as these are not varsity programs.

Please carefully review your **health insurance coverage** options. All students are enrolled in Yale Health Basic Coverage at no additional charge. Yale Health Hospitalization/Specialty Care coverage is available at an additional cost. For more detailed information review the [Student Handbook](#). Before you decide to waive (decline) enrollment in Yale Health Hospitalization/Specialty Care coverage, please consider the following questions:

- Does your health insurance provide **out-of-area coverage for non-emergency and emergency care**?
- Does your health insurance have an **out-of-area/out-of-network deductible**?
- Does your health insurance require a **referral from your primary care clinician within your local network**?
- Does your health insurance require **prior authorization/pre-certification for special tests** (e.g., MRI, CT scan, and Ultrasound)?

*Please note: a prior authorization/pre-certification requirement may cause delays in your medical care and/or participation in your sport.*

If you choose to retain Yale Health’s Hospitalization/Specialty Care coverage and are injured while participating in a varsity sport, you will receive your initial care from the Yale Athletic Medicine Team. If your injury requires further testing and/or treatment you will be treated within the Yale Health network of clinicians/specialists and at Yale-New Haven Hospital, if required, with a minimal co-payment.

If you decide to waive (decline) Yale Health’s Hospitalization/Specialty Care coverage and are injured, you will still receive your initial care from the Yale Athletic Medicine Team. However, if you require further testing (e.g., MRI, CT scan, Ultrasound, etc.), a referral to a specialist, or surgery, it will **not** be covered under Yale Health Basic, and you will need to use your own/private insurance plan. We will work with you to arrange for treatment, but please be aware that this may result in delays, additional costs or the need to return home for treatment depending upon your individual coverage. **Again, if you decide to waive, you cannot assume that Yale will cover the cost of specialty care even though the injury occurred during a Yale varsity event.**
If you have any questions about insurance coverage contact Member Services at 203-432-0206 or member.services@yale.edu. If you have any questions pertaining to the Athletic Medicine Department, e-mail yhathleticmed@yale.edu.

**Required documentation for all athletes:**
- Intercollegiate Pre-Participation Health Evaluation
- Sickle Cell trait lab results

**Additional documentation:**
- CBC and Ferritin level (for female athletes)
- MRI or other prior diagnostic imaging (if applicable)
- Surgical or medical notes (if applicable)
- NCAA ADHD Medical Exception Reporting Form and documentation (if applicable)

Sincerely,

Stephanie Arlis-Mayor, MD  
Chief of Athletic Medicine

Matt Lynch, MD  
Deputy Chief of Athletic Medicine
Please use the checklist below to ensure that you have all of your documentation completed and submitted for intercollegiate athletic participation.

☐ 1. Completed and Signed Intercollegiate Pre-Participation Health Evaluation Form. *Must be signed by your private medical provider.*

☐ 2. Sickle Cell Trait Test Results included with Intercollegiate Pre-Participation Physical Evaluation form. *This is an NCAA requirement.*

☐ 3. If you are taking ADHD or ADD medication, then you must provide the required documentation as noted on question #5 of the Intercollegiate Pre-Participation Evaluation Form. *This is an NCAA requirement.*

☐ 4. If you have had ANY significant injuries or medical problems please provide: diagnostic reports (MRI, CT, X-rays, etc.), clinical notes, and laboratory results.

☐ 5. Bring your current insurance card with you to Yale along with a copy of the front and back of the card.

☐ 6. Complete the Designation of Patient Spokesperson if you would like us to be able to discuss your medical issues while you are on campus. Both you and your parent must sign the form.

☐ 7. **FEMALE ATHLETES ONLY**- We strongly recommend a Complete Blood Count and a Ferritin level blood test and their results. This information is due to the high prevalence of anemia and low iron in our female athlete population.

☐ 8. Make two copies of the forms and supporting documents. Keep one copy for your records, and mail one copy to: Yale Health Center, Athletic Medicine, P.O. Box 208237, New Haven, CT 06520-8237 or email them to yhathleticmed@yale.edu.
Intercolligate Pre-Participation Health Evaluation

Last Name: ___________________________  First Name: ___________________________  Date of Birth: ____________

Email: ___________________________  Cell Phone: ___________________________  Varsity Sport(s): ___________________________

Mailing Address (include street, city, state and zip code):

GENERAL MEDICAL HISTORY Please check yes or no

1. Has a doctor ever denied or restricted your participation in sports for any reason? __________
   If yes, why? __________

2. Were you ever hospitalized for medical or surgical reasons including one-day surgery? If yes, please indicate:
   Hospital: ___________________________  Year: _____  Reason: ___________________________
   Hospital: ___________________________  Year: _____  Reason: ___________________________

   Please send to Yale any significant medical reports or x-rays related to these hospitalizations.

3. Do you take prescription or non-prescription medications on a regular basis? Include
   If yes, please list names and dosages:
   Name of Medication ___________________________  Dosage ___________________________
   Name of Medication ___________________________  Dosage ___________________________
   Name of Medication ___________________________  Dosage ___________________________
   Name of Medication ___________________________  Dosage ___________________________
   Name of Medication ___________________________  Dosage ___________________________

4. Did you receive the required vaccinations: meningitis, MMR and varicella?

5. Have you ever been treated for ADHD or ADD? __________  If yes, be aware that many medications for the treatment of ADHD and
   ADD (which could include generic or trade names of the following medications: Adderal, Amphetamine compounds,
   Benephizilmine, Concerta, Daytra, Lisdesaxafetamine, Metadate, Methamphetamine, Methyl, Methylpemidate,
   Pemoline, Ritalin and Vyvanse) are now banned substances by the NCAA and therefore require specific documentation for
   an exemption for use. For further information go to: https://www.ncaa.org/sites/default/files/ADHD%20reporting%20form.pdf

6. You must have Sickle Cell Trait testing done prior to coming to Yale. NCAA guidelines require laboratory results of Sickle
   Cell Trait results prior to athletic participation. This test is sometimes done at birth. You may want to check with your
   pediatrician's office for sickle cell trait documentation. If no documentation exists, then a sickle cell test must be
   performed. The documentation must be attached to this form or you will not be able to practice until it is received.

   Documentation Attached

GENERAL SYSTEMS-If you answer yes to any of the following questions, please provide clinic notes, diagnostic imaging
reports and/or laboratory results

7. Do you have asthma or do you wheeze or cough with exercise? __________  If you have asthma and are treated with an inhaler, please provide
   medical documentation of diagnosis (i.e., PFT’s)

8. Do you have a bleeding disorder or have you ever been anemic?

9. Are you on a specific diet or do you avoid certain types of foods?

10. Do you have or have you previously had an eating disorder?

11. Have you ever lost more than 10 pounds in one year?

12. Have you ever or do you currently have any form of cancer?

13. Do you have an endocrine abnormality (thyroid, adrenal)? If so, provide details

14. Do you have diabetes?

15. Do you have liver or kidney disease?

16. Do you have only one kidney?

17. Do you have an undescended or absent testicle?

18. Do you have a chronic skin problem/rash or skin infection?

19. Have you recently had a significant viral infection, such as mononucleosis? If so provide details

   and when this happened?

CARDIAC ASSESSMENT-If you answer yes to any of the following questions, please provide clinic notes, diagnostic imaging
reports and/or laboratory results

20. Do you have high blood pressure, high cholesterol or been told you have a heart murmur?

21. Have you ever passed out or nearly passed out DURING or AFTER exercise? If yes, when?

22. Have you ever fainted or lost consciousness when exposed to heat, or had a heat-related illness?

23. Have you ever had heart palpitations, chest pain or difficulty breathing with exercise?

24. Do you have a heart problem or been limited from sports because of a heart problem?

25. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram, holter monitor)

NEURO ASSESSMENT-If you answer yes to any of the following questions, please provide clinic notes, diagnostic imaging
reports and/or laboratory results

26. Have you ever had a head injury or concussion? __________  If yes, how many? __________  When?

27. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
   If yes, when?

Signature of Healthcare Provider (Parent or guardian cannot sign as the healthcare provider) ____________________________________________
28. Do you have a seizure disorder (epilepsy) or have you ever had a seizure?  
29. Have you ever had a neck or spine injury or a stress fracture of the back?  
30. Have you ever had a pinched nerve (“burner”)? If yes, how often?  

**EENT ASSESSMENT** If you answer yes to any of the following questions, please provide clinic notes, diagnostic imaging reports and/or laboratory results.  
31. Do you have significant hearing loss in one or both ears or a history of perforated eardrum?  
32. Have you had a retinal detachment or serious eye injury?  
33. Do you wear glasses or contact lenses during sports participation? (No additional information required)  
34. Is your corrected vision in one or both eyes 20/40 or weaker?  
35. Have you ever sustained a nasal fracture? If so, when?  
36. Do you wear any dental appliances (braces, false teeth)? (No additional information required)  

**MUSCLEOSKELETAL INJURIES** Please carefully list below any musculoskeletal injuries (fractures, stress fractures, torn ligaments, etc.) that you have sustained which restricted your participation in regular activity for a week or more. Please send any significant clinical notes, diagnostic reports and x-rays/MRI/CT related to these injuries.  

<table>
<thead>
<tr>
<th>Injured Area</th>
<th>Diagnosis (Fracture, sprain, strain, dislocation, overuse, etc.)</th>
<th>Side R/L/NA</th>
<th>Year Injury Occurred</th>
<th>Resolved YES NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/Face</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck/Back</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest/Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/Hand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee/Lower Leg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot/Ankle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other fracture or stress related injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY MEDICAL HEALTH**  
38. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?  
39. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  
40. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?  
41. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  
42. Does any family member have a chronic health condition (i.e., diabetes, cancer, heart issues)? If so, please list:  

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FEMALE ATHLETES ONLY** – Please complete  

A. Have you begun your menstrual periods?  
B. Do you have disabling cramps with your menstrual periods?  
C. Have you ever gone regularly 3 months or more without menstrual periods?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any other medical problems you would like to discuss with the team physician?  
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________

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

**Student’s Signature**  

**Date**  

**II. CLINICIAN’S STATEMENT:** Please review the preceding information on pages 1 and 2 then circle the appropriate permission for participation, and sign both pages.  

The student can:  

A. Can participate fully in an intercollegiate athletic program.  
B. Should have the following health problems evaluated or treated before participation recommendations can be made:  
C. Should not participate in the following sports:  

**Sickle Cell Trait Testing Documentation Attached**  
**ADHD Documentation Attached (if applicable)**  

**Recommendations:**  
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________

**Signature of Healthcare Provider (Parent or guardian cannot sign as the healthcare provider)**  

**Date**  
**Phone**  

**Print Name of Healthcare Provider**  
**Address (include city and state)**  
**Fax**  

Rev. 7/20
Designation of Patient Spokesperson

I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the family member or friend named below to discuss and access my protected health information (PHI) to assist in my care. I am also aware that I may limit access to my records if I specify below.

Patient Information – Please Print

| Patient Name: ______________________________ | Date of Birth: _______ | Phone Number: ________________ |
| Address: ________________________________ |

Authorized Individual - Please Print

| Name: ________________________________ | Relationship to Patient: ________________________________ |
| Address: ________________________________ |
| Phone Number: ________________________________ |

I grant to the individual named above access to:

___All of my PHI – note separate box below is also required for HIV, psychiatric and substance abuse access.

___Other - Specify limits or specific health care incident ________________________________

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that if I sign this box, I am specifically authorizing my HIPAA Representative access to information relating to:

___ Substance Abuse (including alcohol/drug abuse)
___ Mental Health
___ Psychotherapy Notes
___ HIV related information (including AIDS related testing)

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Signature of patient for this box: ________________________________ Date: _______

1. I understand that I may revoke these designations at any time by notifying the appropriate Yale University Department/Physician in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Yale University prior to their receipt of the revocation.
2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.
3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPAA.
4. I understand that this Authorization will: (Must check one)
   ( ) expire 1 year from the date executed; or
   ( ) be effective for the lifetime of the patient unless revoked (see #1 above)

Signature of Patient/ Personal Representative: ________________________________ Date: _______

Name of Patient Spokesperson: ________________________________ Relationship to Patient: ________________________________

Signature of Patient Spokesperson: ________________________________ Date: ______

*YOU MAY REFUSE TO SIGN THIS FORM*

Please mail, fax, or scan completed forms to: Yale Health, P.O. Box 208237, New Haven, CT 06520-8237 or fax to 203-436-5536 or email to mailto:yhmedicalrecords@yale.edu.
Designation of Contact Information

Use of email, text messaging, voice mail

Email and text messaging allows health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission. Similarly, detailed voice mail messages allow clinicians to provide test results, medical and referral information to you in a timely manner but if the voice mail system is shared, the information could be heard by others.

We recommend that our patients sign up for our patient portal, MyChart, which allows secure communication with your caregiver team.

If you would like us to send you email and/or text messages or leave detailed voice mails that contains your health information, please check the appropriate boxes and sign this consent below. You are not required to authorize the use of email, voice mail and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email, voice mail and/or text messaging we will continue to use U.S. Mail or telephone to communicate with you.

I authorize the use of the following communication methods when communicating with me and my authorized individual (check all that apply):

☐ E-mail address that may be used to send information to YOU: ________________________________

☐ Phone number of text messages to YOU: ________________________________

☐ Phone number for detailed voice mail to YOU: ________________________________

☐ E-mail address that may be used to send information to your PATIENT SPOKESPERSON: ________________________________

☐ Phone number that may be used to text messages to your PATIENT SPOKESPERSON: ________________

☐ Phone number for detailed voice mail to your PATIENT SPOKESPERSON: ________________

Signature of Patient/Personal Representative: __________________ Date: __________

Name of Personal Representative: __________________ Relationship to Patient __________________

*YOU MAY REFUSE TO SIGN THIS FORM*

Please mail, fax, or scan completed forms to: Yale Health, P.O. Box 208237, New Haven, CT 06520-8237 or fax to 203-436-5536 or email to mailto:yhmedicalrecords@yale.edu.
COVID-19 Pre-Participation Questionnaire for Athletes

Have you been diagnosed with a COVID-19 infection?

If yes: When?

How were you diagnosed (nasal swab, blood test, clinical evaluation)?

Were you hospitalized?

Do you have any ongoing symptoms (cough, weakness, palpitations, decreased exercise tolerance, etc)?

In the past 2 weeks, have you spent significant time (>15 minutes in enclosed space) with anyone diagnosed with COVID-19 infection?

In the last 8 months, have you had any prolonged illnesses or reason to suspect you had a COVID-19 infection?

In the last 8 months, have you lived with anyone diagnosed with COVID-19?

Do you have any medical conditions below that would put you in a high risk category for COVID-19 infection (please select all that apply)?

<table>
<thead>
<tr>
<th>Chronic Kidney Disease</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Neurologic conditions</td>
</tr>
<tr>
<td>Immunocompromised State from solid organ transplant, blood or bone marrow transplant, immune deficiency, HIV, corticosteroid use, immunosuppressing medication use</td>
<td>Heart condition (heart failure, cardiomyopathy, coronary artery disease)</td>
</tr>
<tr>
<td>Obesity (BMI &gt;30)</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Pulmonary fibrosis</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>Smoking (including vaping)</td>
</tr>
<tr>
<td>Type 1 diabetes mellitus</td>
<td>Type 2 diabetes mellitus</td>
</tr>
<tr>
<td>Asthma (moderate to severe)</td>
<td>Thalassemia</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>Liver Disease</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>