

Yale University Health Services

17 Hillhouse Avenue
P.O. Box 208237
New Haven, CT 06520-8237

May 2008

Dear Incoming Freshman:

Welcome and congratulations on your acceptance to Yale University. In order to compete in a **varsity athletic program** you must complete and return the Intercollegiate Athlete Athletic Medicine form. Please ask your clinician to complete and sign Section II. This will assist you with obtaining medical clearance for participation. The form must be received by **August 1, 2008. You will not be permitted to participate in any varsity try-out, practice or game until we receive the completed form.**

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.

If you are injured while participating in a varsity sport you will be cared for by the Yale Athletic Medicine Team. This medical care is included in the Yale Health Plan (YHP) Basic Coverage which students are enrolled in at no additional cost. If you require further testing (e.g., MRI, CT scan, Ultrasound, etc.) or surgery and you have YHP Hospitalization/Specialty Coverage you will be treated within our network of clinicians and at Yale New Haven Hospital with no deductible and no co-pay. If you decide to waive YHP Hospitalization/Specialty Coverage and are insured through another insurance plan we will work with you to arrange for treatment. However, please be aware that this may result in delays, additional costs or the need to return home for treatment depending upon your coverage.

Please carefully review **your health insurance coverage** options. Before you decide to waive enrollment in YHP Hospitalization/Specialty Coverage please consider the following questions:

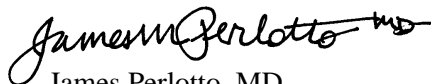
- Does your health insurance provide **out-of-area coverage for non-emergency and emergency care?**
- Does your health insurance require **prior authorization/pre-certification for special tests** (e.g., MRI, CT scan, and Ultrasound)? Please note: a prior authorization/pre-certification requirement may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

If you choose YHP as your **primary insurance**, please review the services and coverage at <http://www.yale.edu/uhs/pdf/studenthb.pdf>. If you have any questions about coverage please contact Member Services, member.services@yale.edu.

If you have any questions pertaining to the Athletic Medicine Department, you may call (203) 432-0334 from 8:30 A.M. – 3:30 P.M., Monday through Friday.

Thank you for your attention to this matter and I look forward to seeing you in September.

Sincerely,



James Perlotto, MD
Chief, Student and Athletic Medicine Departments



**Yale
University
Health
Services**

Intercollegiate Athlete Athletic Medicine Form

Due: August 1, 2008

Return by mail to:
YUHS Office of Athletic Medicine
17 Hillhouse Ave.
P.O. Box 208237
New Haven, CT 06520-8237

Last Name:	First Name:	Date of Birth:
E-mail:	Phone:	Gender
Varsity Sport(s):		

I. MEDICAL HISTORY – answer all questions

	YES	NO
1. Do you have any known allergies? If yes, please indicate type(s): A. Medications, foods _____ B. Bee sting reaction	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently taking any medications on a regular basis? If yes, please list names and dosages: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a concussion? If yes, how many? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a seizure disorder (epilepsy) or have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever lost consciousness when exposed to heat or had a heat-related illness?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is your corrected vision in one or both eyes 20/40 or weaker?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you wear glasses or contact lenses during sports participation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had a retinal detachment or serious eye injury?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have significant hearing loss in one or both ears?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have ventilation tubes or a perforated eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you wear any dental appliances (braces, false teeth)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever sustained a nasal fracture?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had recurrent pneumonias?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have asthma or do you wheeze with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have a heart problem or been limited from sports because of a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever fainted or nearly fainted with strenuous exercise?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had heart palpitations, chest pain or difficulty breathing with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have recurrent diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you on a specific diet (i.e., vegetarian)?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you over the past five years lost more than 10 pounds in one year?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you have or have you previously had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have a liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you have only one kidney?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have a kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you have an undescended or absent testicle (if applicable)?	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have an endocrine abnormality (thyroid, adrenal)?	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have a bleeding disorder or have you ever been anemic?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you have a chronic skin problem/rash?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever or do you currently have any form of cancer?	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you ever had a severe viral infection causing you to miss more than a month of school?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you ever had a neck or spine injury or a stress fracture of the back?	<input type="checkbox"/>	<input type="checkbox"/>
34. Do you get recurrent low back pain?	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you ever had a pinched nerve (“burner”)? If yes, how often _____	<input type="checkbox"/>	<input type="checkbox"/>
36. Did you receive the hepatitis vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
37. Did you receive the influenza vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
38. Did you receive the meningitis vaccination?	<input type="checkbox"/>	<input type="checkbox"/>

39. Please carefully list below any musculoskeletal injuries that you have sustained, in your athletic career, which restricted your participation in regular activity for a week or more.

Please bring to Yale any significant medical reports or x-rays related to these injuries.

Injured Area	Diagnosis (Fracture, sprain, strain, dislocation, overuse, etc.)	Side		Resolved?	
		R/L/NA	Year	Yes	No
<input type="checkbox"/> Shoulder					
<input type="checkbox"/> Elbow					
<input type="checkbox"/> Wrist					
<input type="checkbox"/> Hand					
<input type="checkbox"/> Hip					
<input type="checkbox"/> Knee					
<input type="checkbox"/> Ankle					
<input type="checkbox"/> Foot					
<input type="checkbox"/> Muscle/tendon					
<input type="checkbox"/> Bone (fracture, stress fracture)					
<input type="checkbox"/> Other					

40. Has any family member died suddenly at less than 40 years of age of causes other than an accident? **YES** **NO**
 What was the cause? _____

41. Does any family member have Marfan's syndrome?

42. Has any family member had a heart attack at less than 55 years of age?

43. Does any family member have a chronic health condition? If yes please explain.

44. Were you ever hospitalized for medical or surgical reasons including one-day surgery? If yes, please indicate:

Hospital: _____ Year: _____ Reason: _____

Hospital: _____ Year: _____ Reason: _____

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

45. Do you have any other medical problems or issues you would like to discuss with the team physician?

46. **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?

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 circle appropriate permission for participation and include specific training requirements.

A. This student can participate in a full intercollegiate athletic program with the exception of the following sports?

B. This student should have the following health problems evaluated or treated before participation recommendations can be made: _____

C. This student should not participate in: _____

D. Recommendations: _____

 Clinician's Signature

 Date