YALE

May 2024

Dear Yale Student-Athlete:

Welcome to the Yale Athletics community!

Yale Health and Yale Medicine provide every student-athlete with a multidisciplinary, comprehensive, quality medical team trained in sports medicine. We provide a safe environment focusing on the health and wellness of our Yale Student-Athletes. Please review the following information.

Our team is comprised of:

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

Yale Health and Yale Athletic Medicine collaborate with Yale Medicine and the Yale-New Haven Healthcare System to access exceptional specialty medical and surgical care.

Prior to your arrival at Yale:

- Sign up and create an EPIC MyChart account (https://mychart.ynhhs.org) as this will be the way that you will communicate with your medical team during your time at Yale.
- In order to be cleared to participate on your varsity team, you must complete and return the ***Intercollegiate Pre-Participation Medical Evaluation*** form below.
- Additionally, you must also complete all forms and pre-admission requirements of Yale College.
- The athletics forms must be completed, signed by your medical provider and received by Yale Athletic Medicine by **July 1, 2024.**
- Please submit your athletic forms to yhathleticmed@yale.edu or fax to 203-432-5641 Attn: Athletic Medicine

On arrival at Yale:

- Prior to participation in any athletic training, all student-athletes undergo a comprehensive on-campus medical evaluation with the Athletic Medicine Team.

- As part of this evaluation, we will review your medical history and surgical history.
- This will also include 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.

Student-athletes with a prior diagnosis of COVID-19 may have an additional focused medical evaluation. This evaluation may warrant further investigation, including cardiac and/or pulmonary testing.

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 student-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 provider. 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.

Health Insurance

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*** (ie. MRI, CT scan, 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 and rapid authorization.

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 the Yale Health Basic Plan, and you will need to use your own/private insurance plan primarily for this additional care. Authorization for your care will need to be obtained prior to treatment/testing.

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 Yale Health's Hospitalization/Specialty Care coverage, authorization for your care/testing will be required and make take several days (at least) to obtain.**

If you have any questions about Yale Health insurance coverage, contact Yale Health Member Services at 203-432-0246 or member.services@yale.edu. If you have any questions pertaining to the Athletic Medicine Department, email yhathleticmed@yale.edu

Required documentation for all student athletes:

- Intercollegiate Pre-Participation Health Evaluation including updated immunization records
- Sickle cell trait lab results

Additional Documentation: see checklist below for details

- CBC and ferritin level (for female athletes)
- MRI or other prior diagnostic imaging, include images (if applicable)
- Surgical or medical notes (if applicable)
- NCAA ADHD Medical Exception Reporting Form and documentation (if applicable)

Sincerely,

Elizabeth Gardner

Elizabeth Gardner, MD
Head Team Physician, Yale Athletics
Associate Professor
Yale School of Medicine Department of Orthopedic Surgery

Yale University Intercollegiate Athlete Medical Information Checklist

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, concussions, surgeries or medical problems within the last 3 years please provide: diagnostic reports and CD of images (MRI, CT, X-rays, etc.), clinical notes, operative reports, and laboratory results.
- ❒ 5. Bring your current medical 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. Complete the Designation of Contact Information in this packet regarding methods of communication about your medical issues.
- ❒ 8. **FEMALE ATHLETES ONLY**- We strongly recommend a Complete Blood Count and a Ferritin level blood test and the results. This information is due to the high prevalence of anemia and low iron in our female athlete population.
- ❒ 9. Keep one copy of the forms and supporting documents. Sign up and create an EPIC MyChart account (https://mychart.ynhhs.org). Keep a copy of your forms and records and return one copy by email to Yale Health secure email: yhathleticmed@yale.edu; **or** fax to 203-432-5641, Attn: Athletic Medicine.

Yale

Intercollegiate Pre-Participation Health Evaluation

Due Date: July 1, 2024
Return to Yale Health, Athletic Medicine
Email: yhathleticmed@yale.edu
Fax 203-432-5641

HISTORY FORM To be completed by the student athlete

Legal Name: _____ Preferred Name: _____

Date of birth: _____ Email: _____ Cell Phone:_____

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

Pronouns (check all that apply) ❒ he/him/his ❒ she/her/hers ❒ they/them/theirs ❒ other:_____

Gender Identity: ❒ Man ❒ Woman ❒ Transgender Man ❒ Transgender Woman Other: _____

Varsity Sport(s): _____

List past and current medical conditions.

_____

_____

Have you ever had surgery? If yes, list all past surgical procedures. Please provide related clinical and operative notes for any within the past 3 years.

_____

_____

Medicines and supplements: list all current prescriptions, over-the-counter medications, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, stinging insects).

_____

_____

Have you ever been treated for ADHD or ADD? ___Yes ___No

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, Benzphetzmine, Concerta, Daytrana, Lisdexamfetamine, Metadate, Methamphetamine, Methylin, Methylpemidate, Pemoline, Ritalin and Vyvanse) are now banned substances by the NCAA and therefore require specific documentation for an exemption for use. Visit https://yalehealth.yale.edu/department/athletic-medicine for the ADHD Packet, a portion of which must be completed by your physician.

Patient Health Questionnaire Version 4 (PHQ4)
Over the last 2 weeks, how often have you been bothered by any one of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Student Name: _____

	GENERAL QUESTIONS ABOUT YOU (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	**YES**	**NO**
1.	Do you have any concerns that you would like to discuss with your provider?		
2.	Has a provider ever denied or restricted your participation in sports for any reason?		
3.	Do you have any ongoing medical issues or recent illness?		
	HEART HEALTH QUESTIONS ABOUT YOU	YES	NO
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7.	Has a doctor ever told you that you have any heart problems (high blood pressure or murmur)?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?		
9.	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10.	Have you ever had a seizure?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
11.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12.	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
	BONE AND JOINT QUESTIONS	**YES**	**NO**
14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or a game?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		
	MEDICAL QUESTIONS	**YES**	**NO**
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17.	Are you missing a kidney, an eye, a testicle (male), your spleen, or any other organ?		
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20.	Have you ever been diagnosed with a concussion? If yes, how many? _____		
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22.	Have you ever become ill or passed out while exercising in the heat?		
23.	Do you or does someone in your family have sickle cell trait or disease? 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 exits, 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. ❒ Document attached		
24.	Have you had or do you have any problems with your eyes or vision?		
25.	Do you worry about your weight?		
26.	Are you trying to or has anyone recommended that you gain or lose weight?		

		YES	NO
27.	Are you on a special diet or do you avoid certain types of foods or food groups?		
28.	Have you ever had an eating disorder?		
INFECTIOUS DISEASE QUESTIONS		**YES**	**NO**
29.	Have you ever been diagnosed with mononucleosis?		
30.	Have you ever been diagnosed with COVID-19 infection? If yes: When _____Were you hospitalized? Yes/No Do you have any ongoing symptoms? Yes/No Did you have any additional medical evaluation such as ECG or echocardiogram? If yes, please provide documents.		
FEMALES ONLY		**YES**	**NO**
31.	Have you ever had a menstrual period?		
32.	How old were you when you had your first menstrual period?		
33.	When was your most recent menstrual period?		
34.	How many periods have you had in the last 12 months?		

Explain "Yes" answers here:

Do you have any other medical problems or mental health concerns you would like to discuss with the team physician?

I hearby state that to the best of my knowledge, my answers to the questions on this form are complete and correct.

_____ _____
Student Athlete's Signature **Date**

_____ _____
Signature of parent or guardian if student athlete is younger than 18 years old **Date**

_____ **I have reviewed the preceding pages (History Form).**
Clinician initials

PHYSICAL EXAMINATION FORM **To be completed by the healthcare professional**

EXAMINATION		
Height: Weight: BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ❒ Yes ❒No		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficientcy)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		

CLINICIAN'S STATEMENT: I have examined the student named on this form and completed the pre participation evaluation. Please review the preceding information and then **circle** the appropriate permission for participation, and sign below.

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: _____

D. Should not participate in any sports.

❒ **Sickle Cell Trait testing documentation attached** ❒ **ADHD documentation attached (if applicable)** ❒ **Immunization record attached**

___

Recommendations:_____

Name of healthcare professional_____ Date: _____

Address: _____ Phone: _____

Signature of healthcare professional: _____, MD, DO, NP, or PA

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: _____

Address: _____

Phone Number:_____ Relationship to Patient: _____

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 fax completed forms to 203-432-5641 or scan and email completed forms to yhathleticmed@yale.edu

Yale HEALTH

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 require 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 return scanned forms to email yhathleticmed@yale.edu or fax to 203-432-5641 Attn: Athletic Medicine