Returning Student-Athlete Medical Clearance Form

Please have your medical provider complete this form in its entirety, including the provider’s signature, date and address/phone number. Exams must be completed within six (6) months of the start of pre-conditioning practice. Once completed, please scan this form and email it to the CCSU Student Wellness Center’s email address: sws@ccsu.edu. Incomplete forms will not be accepted.

Student Name: _____________________________________   Banner ID#: _____________________
Sport(s): __________________________________________  Exam Date: _____________________
Tetanus/Tdap Vaccine (has to be within last ten years)___________

Please answer Yes/No to the Following Questions.

_____ Any history of fast or slow heart rhythms, irregular heartbeats or palpitations during or after exercise?
   If yes, please describe: ___________________________________________________________________

_____ Death of a relative before the age of 50 due to unknown cause or sudden/unexpected heart disease?

_____ Disability from heart disease in a close relative <50 years of age?

_____ Specific knowledge of certain cardiac conditions in self or family members?
   If yes, please describe: ___________________________________________________________________

_____ Does student have a condition that limits ability to participate in the indicated sport(s)?
   If yes, please describe: ___________________________________________________________________

_____ Has student had any significant illnesses, hospitalizations and/or injuries (including body/concussion or other head injury/motor vehicle accident) in the past year?
   If yes, please describe: ___________________________________________________________________

_____ Does student have any history of fainting or heat-related illness?
   If yes, please describe: ___________________________________________________________________

_____ Does student have any history of asthma, wheezing or shortness of breath out of the ordinary during or after exercise?
   If yes, please describe: ___________________________________________________________________

_____ If applicable, has student missed more than three consecutive menstrual periods in the last year?
   If yes, please describe: ___________________________________________________________________
Exam: Fill in response:

Height: ____________      Weight: ____________      Pulse: ____________
Temperature: ______   Blood Pressure: Right: ______   Left: _______

Marfan stigmata: (assess for kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

Heart: (Please auscultate sitting, standing, supine, and with squat or valsalva)

Sitting: ____________________________________________
Standing: ____________________________________________
Supine: ____________________________________________
Squat/Valsalva: _______________________________________
Pulses (include simultaneous, femoral and radial pulses): ____________________________________________

Lungs: ____________________________________________
Extremities: ________________________________________

Please check one of the two below:

____ I have examined the above-named student-athlete and completed a pre-participation assessment. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as indicated above. If conditions arise after the athlete has been cleared for participation, clearance may be rescinded until the problem is resolved or clarified. The student-athlete is cleared to participate in Division I varsity sports without restrictions.

____ The student-athlete is NOT cleared to participate in Division I varsity sports due to the following reasons:

_______________________________________________________________________________
_______________________________________________________________________________

Please provide any additional documentation (including but not limited to EKG, PFT’s, lab results, radiology reports, consultations, etc.).

Medical Provider Signature: ____________________________________________ Date: ______________

Print Provider Name: __________________________________________________

Provider Address: _____________________________________________________ Phone: ______________