Cornell College | STUDENT HEALTH SERVICES

2026–27 Student-Athlete Clearance Form

To be completed by MD, DO, NP, or PA for all Cornell student-athletes.

OFFICE USE ONLY

Name ______
Birthdate ______
SSN ______
Sport ______

Clearance

RETURNING Student-Athletes: This physical must be completed and returned to Cornell College's Sports Medicine Department. All returning athletes must have the Student Medical History, Physical Examination, and Clearance Form completed and turned in by **July 31, 2026** before they will be allowed to participate/practice in any athletics at Cornell College.

1

Name: ______ Date of birth: ____/____/____

Cleared without restrictions

Cleared, with recommendation for further evaluation or treatment for: ______

Not cleared for: All sports Certain sports: ______ Reason: ______

Recommendations: ______

Emergency Information

2

Please note any medical concerns that may impact safety of the athlete (E.g. any history of seizures, anaphylaxis, fainting, narcolepsy, cardiac conditions): ______

Please list all medications the athlete is currently taking: ______

Sickle Cell Status

Required for first years and transfers

3

Positive Negative

Immunizations

4

E.g. tetanus/dipthera/pertussis; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella

Up to date Not up to date — Specify: ______

Provider Signature

Signature required

5

Name of provider (print/type): ______

Signature of medical provider:

Date

MD DO PA NP Phone number: ______

Address: ______

NCAA Attention Deficit Hyperactivity Disorder (ADHD) Guidelines

6

Athletes: If you have been diagnosed with ADHD and are currently under medication, you must provide documentation per NCAA guidelines.

crnl.co/ADHD-guidelines

319.895.4292 | student_health@cornellcollege.edu

Emergency Contacts

7

Contact name: ____________________

Relationship to you: ____________________

Daytime phone number: ____________________

Contact name: ____________________

Relationship to you: ____________________

Daytime phone number: ____________________

Release of Information

Signature required

8

I hereby authorize the Ebersole Health & Wellbeing Center to release any information related to my athletic participation to the Cornell College's Sports Medicine Department. I also authorize Cornell College's Sports Medicine Department to release any medical information to Ebersole Health & Wellbeing Center or to Cornell College's Insurance Company claims administration services.

Signature of student:

Date

Signature of parent/guardian:

Date

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