

UNIVERSITY OF ARKANSAS SPORTS MEDICINE FOOTBALL CAMP MEDICAL CLEARANCE FORM

Directions to the Examining Physician:

1. Please review and sign Page 1, clarifying any 'Yes' answers.
2. Please complete and sign the exam form on Page 2.
3. Please indicate your recommendations.
4. Please return the completed form to the student.

Name: _____	Sex: _____	Age: _____	DOB: _____
Address: _____		Phone: _____	
SPORT: _____		DATE OF EXAM: _____	

Please explain any 'Yes' answers below

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
1. Have you had a medical illness or injury since your last check-up or sports physical? Do you have an ongoing or chronic illness?	_____	_____	6. Have you ever passed out during or after exercise? Have you experienced dizziness during or after exercise?	_____	_____
2. Have you ever had surgery? Are you currently taking any prescription or nonprescription (over-the-counter) medication or pills or using an inhaler?	_____	_____	Have you ever had chest pain during or after exercise? Do you get tired more quickly than normal during exercise?	_____	_____
Are you allergic to any medications?	_____	_____	Have you ever had an abnormally racing heart or skipped heartbeats?	_____	_____
4. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory?	_____	_____	Have you ever been told you have high blood pressure or high cholesterol?	_____	_____
Have you ever had a seizure?	_____	_____	Have you ever been told you have a heart murmur?	_____	_____
Have you ever had numbness or tingling in your arms, hands, legs or feet?	_____	_____	Has any family member or relative died of heart problems or of sudden death before the age of 50?	_____	_____
Have you ever had a stinger, burner or pinched nerve?	_____	_____	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____
5. Have you ever had a sprain, strain, or swelling after injury? Have you ever fractured any bones or dislocated any joints?	_____	_____	Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____	7. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma?	_____	_____
			8. Have you ever become ill from exercising in the heat?	_____	_____
			9. Are you missing one of the following: kidney, eye, testicle (or an undescended testicle)?	_____	_____
			10. Have you ever been diagnosed with ADD/ADHD?	_____	_____

Explain any "Yes" answers here:

I hereby state that, my answers to the above questions are complete and correct. I understand that I am responsible for any medical bills arising from my examination.

Signature of student: _____ Date: _____

I have reviewed the questions with the student athlete.

Signature of physician: _____ Date: _____

PHYSICAL EXAMINATION

Name: _____			
Height: _____	Weight: _____	Pulse: _____	BP: _____ / _____
Vision R 20 / : _____	L 20 / : _____	Corrected: Y N	

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

ASSESSMENT:

RECOMMENDATIONS:

- I find nothing in the history and physical examination to preclude participation. **I recommend full participation.**
- One or more issues have been identified that need to be addressed prior to participation.
- I do not recommend participation for this individual. Reason: _____

Name of physician (print): _____		Date: _____
Signature of physician: _____		Phone: _____
Physician Address: _____		