UNIVERSITY OF ARKANSAS SPORTS MEDICINE
SOCCER 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

		Yes	No
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?		
2.	Have you ever had surgery?		
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medication or pills or using an inhaler?		
	Are you allergic to any medications?		
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 had a seizure?		
	Have you ever had numbness or tingling in your arms, hands, legs or feet?		
	Have you ever had a stinger, burner or pinched nerve?		
5.	Have you ever had a sprain, strain, or swelling after injury?		
	Have you ever fractured any bones or dislocated any joints?		
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
6.	Have you ever passed out during or after exercise?		
	Have you experienced dizziness during or after exercise?		
	Have you ever had chest pain during or after exercise?		
	Do you get tired more quickly than normal during exercise?		
	Have you ever had an abnormally racing heart or skipped heartbeats?		
	Have you ever been told you have high blood pressure or high cholesterol?		
	Have you ever been told you have a heart murmur?		
	Has any family member or relative died of heart problems or of sudden death before the age of 50?		
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
	Has a physician ever denied or restricted your participation in sports for any heart problems?		
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): _____
Signature of physician: _____ Date: _____
Physician Address: _____ Phone: _____