

2015 UNC Soccer Camp MEDICAL FORM

No camper will be allowed to participate without this form completed and signed

Camp Session Attending: _____

Camper's Name _____ D.O.B. _____ Age _____

Camper's Physician _____ Physician's Phone # () _____

Physician's Address _____ City _____ State _____

☐ **CLEARED TO PARTICIPATE** *Physician's Signature* _____

☐ NOT CLEARED FOR: _____
(list activities for which camper is not cleared)

ANY RECOMMENDATIONS _____

PARENTS: CHECK APPROPRIATE BOXES AND EXPLAIN ALL "YES" ANSWERS AT BOTTOM OF FORM.
CIRCLE QUESTIONS YOU ARE UNABLE TO ANSWER.

	YES	NO
1. Have you ever had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>
a. Have you ever taken any supplements/vitamins to help you gain/lose weight or improve performance?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies (to food, pollen, insects, medicines, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during exercise or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
a. Have you ever been dizzy after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had chest pain after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you ever had a racing of your heart or skipping of beats?	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
g. Has any family member or relative died of heart problems or sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you had a severe viral infection (i.e. myocarditis or mononucleosis) in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
i. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any current skin problems (i.e. blisters, warts, rash, fungus, itching, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
a. Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you ever had numbness, tingling in your hands, arms, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you have asthma or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee braces, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you wear glasses, contacts, or protective lenses?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
a. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you up to date on your immunizations?	<input type="checkbox"/>	<input type="checkbox"/>
a. When was your last tetanus shot or booster _____?		
b. Have you had chickenpox? _____ If, so, when? _____		

EXPLAIN ALL "YES" ANSWERS HERE _____