2019 UNC Soccer Camp MEDICAL FORM

Campers will not be allowed to participate without this form completed & 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.

Question	YES	NO
1. Have you ever had a medical illness or injury since your last checkup or sports physical?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
3. Are you currently taking any prescription or nonprescription medicine?	☐	☐
a. Have you ever taken any supplements/vitamins to help you gain/lose weight or improve performance?	☐	☐
4. Do you have allergies (to food, pollen, insects, medicines, etc.)?	☐	☐
a. Do you have seasonal allergies that require medical treatment?	☐	☐
5. Have you ever passed out during exercise or after exercise?	☐	☐ a.
Have you ever been dizzy after exercise?	☐	☐
b. Have you ever had chest pain after exercise?	☐	☐
c. Do you get tired more quickly than your friends during exercise?	☐	☐
d. Have you ever had a racing of your heart or skipping of beats?	☐	☐
e. Have you had high blood pressure or high cholesterol?	☐	☐
f. Have you ever been told you have a heart murmur?	☐	☐
g. Has any family member or relative died of heart problems or sudden death before the age of 50?	☐	☐
h. Have you had a severe viral infection (i.e. myocarditis or mononucleosis) in the last month?	☐	☐
i. Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (i.e. blisters, warts, rash, fungus, itching, etc.)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐ a.
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
b. Have you ever had a seizure?	☐	☐
c. Do you have frequent or severe headaches?	☐	☐
d. Have you ever had numbness, tingling in your hands, arms, legs, or feet?	☐	☐
e. Have you ever had a stinger, burner or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
a. Do you have asthma or exercise-induced asthma?	☐	☐
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)?	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
a. Do you wear glasses, contacts, or protective lenses?	☐	☐
12. Have you ever had a sprain, strain, or swelling after injury?	☐	☐

a. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? ☐ ☐

13. Are you up to date on your immunizations? ☐ ☐
    a. When was your last tetanus shot or booster___?
    b. Have you had chickenpox?_If, so, when?_____

EXPLAIN ALL "YES" ANSWERS HERE

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