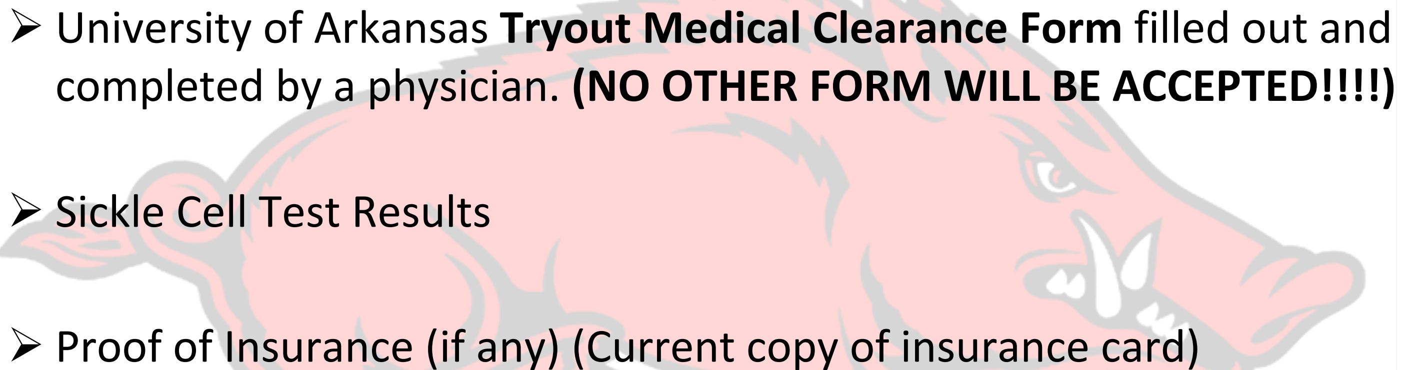
UNIVERSITY OF ARKANSAS

All students interested in trying out for any University of Arkansas Intercollegiate Athletic Team, the documents listed below must be brought with you on your tryout date. You **WILL NOT** be allowed to tryout if these forms are not complete and on file with the University of Arkansas Sports Medicine Staff prior to tryouts.



- University of Arkansas **Tryout Medical Clearance Form** filled out and completed by a physician. **(NO OTHER FORM WILL BE ACCEPTED!!!!)**
- Sickle Cell Test Results
- Proof of Insurance (if any) (Current copy of insurance card)

If after the tryout, you are chosen to be a participant on one of the University of Arkansas' Intercollegiate Athletic Teams, you will be required to undergo a complete physical exam by the University of Arkansas Sports Medicine Staff

TRYOUT 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

#	Question	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: ______________________