2014 NVGAG MEDICAL CLEARANCE INSTRUCTIONS FOR ATHLETES

You must be seen by your VA Primary Care Provider to be medically cleared to participate in the Games.

Reminder: We will not provide routine medical care, replacement medications, replacement equipment or replacement supplies for pre-existing conditions. Athletes must bring enough medication and medical supplies to last through the GAMES. Any medication or medical supplies provided on site will be charged back to the Athlete's medical facility. Narcotic prescriptions will not be filled.

The Veterans Health Care System of the Ozarks (VHSO) has inpatient services. Should a Athlete have a problem that needs attention or treatment in an Emergency Room or local hospital, please inform a coach or local organizing committee staff who will notify the local VA medical staff.

Athletes using oxygen must have their sponsoring VA Medical Center coordinate oxygen services, including supplies, with a local oxygen provider in northwest Arkansas.

Limited medical assistance will be provided 24 hours a day at The Maples dormitory on the University of Arkansas campus. First aid and medical stabilization at the events and activities will also be provided. Ambulance care will be provided as needed.

When registering on June 28, 2014, please tell us if there have been any significant changes in your health since application was completed. These changes include:

- Changes in medication
- Admissions and/or hospitalizations
- New diagnosis, problems, or conditions

Please have your VA Primary Care Provider complete the enclosed Medical Application (VAF 0926e) and submit it, along with a copy of your VA ID card, with your application packet.

ATHLETE NUMBER-OFFICE USE ONLY

OMB Number: 2900-0759
Expiration Date: Xxx, 20XX
Respondent Burden: 20 minutes

Department of Veterans Affairs

ATHLETES MEDICAL INFORMATION

A PHYSICIAN, NURSE PRACTIONER OR PHYSICIAN ASSISTANT MUST FILL OUT AND SIGN THIS FORM

PRIVACY ACT: VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

Dear Provider,
Pending approval, the Veteran patient plans to participate in various athletic events and/or games which may be strenuous and/or dangerous depending on his/her condition. Additionally, should the Veteran patient require personal ADL assistance, please understand this will not be provided by The Veterans Health Care System of the Ozarks (VHSO) and would be a reason not to clear him/her unless he/she is accompanied by a caregiver.

DATE	VA MEDICAL CENTER NAME	WHAT IS YOUR VA STATUS ☐ INPATIENT ☐ OUTPATIENT

NAME *(Last, First, MI)*			ADDRESS *(Street, City, State, Zip Code)*
SOCIAL SECURITY NO. *(Last 4 digits only)*	VETERANS DATE OF BIRTH	AGE	

PLEASE REVIEW VETERAN DEMOGRAPHICS FOR ACCURACY BEFORE YOU COMPLETE THIS FORM.

WEIGHT	PROBLEM LIST *(Active Problems)*	I HAVE REVIEWED THE ACTIVE PROBLEMS AND CONFIRM THAT THIS LIST IS CURRENT ☐ YES ☐ NO
HEIGHT	☐ COPD ☐ HEART FAILURE ☐ HYPERTENSION ☐ DIABETES ☐ OTHER *(List below)*	I HAVE ATTACHED A 12 LEAD EKG *(Completed within the last 6 months) (REQUIRED)* ☐ YES ☐ NO
BLOOD PRESSURE		I HAVE ATTACHED SLEEP STUDY *(Required if using a CPAP/ BIPAP)* ☐ YES ☐ NO
LIST ALL ACTIVE MEDICATIONS		I HAVE REVIEWED THE MEDICATIONS LISTED AND THE VETERAN IS TAKING THEM AS DIRECTED ☐ YES ☐ NO

LAST ADMISSION _____ REASON FOR ADMISSION _____

ALLERGIES _____

IS THE VETERAN VISUALLY IMPAIRED? *(Legally blind)* ☐ YES ☐ NO

IS THE VETERAN HEARING IMPAIRED? ☐ YES ☐ NO

TETANUS TOXOID DATE _____ PLEASE UPDATE TETANUS IF NOT WITHIN 10 YEARS

PPD DATE _____ REQUIRED WITHIN 12 MONTHS IF POSITIVE, SEND CURRENT CHEST X-RAY REPORT TAKEN AFTER POSITIVE PPD

IS THE PATIENT FREE OF COMMUNICABLE DISEASES? *(If no, explain)* ☐ YES ☐ NO _____

CAN HE/SHE TAKE HIS/HER OWN MEDICATIONS? *(If no, explain)* ☐ YES ☐ NO _____

PLEASE ADVISE VETERAN OF THEIR RESPONSIBILITY FOR BRINGING ENOUGH MEDICATION FOR THE TRIP AND THE WEEK.

THE VETERANS HEALTH CARE SYSTEM OF THE OZARKS (VHSO) WILL NOT PROVIDE NARCOTIC REFILLS FOR ANY REASON.

The cost of any medical expenses and/or medications will be charged back to the veteran or the veteran's originating facility.

DOES THE VETERAN NEED ASSISTANCE WITH THE FOLLOWING ADL'S?
☐ AMBULATION ☐ TRANSFER ☐ FEEDING ☐ GROOMING ☐ TOILETING

IS THE VETERAN INCONTINENT OF URINE? *(If yes, please provide the name and telephone number of the accompanying caregiver)* ☐ YES ☐ NO

IS THE VETERAN INCONTINENT OF BOWEL? *(If yes, please provide the name and telephone number of the accompanying caregiver)* ☐ YES ☐ NO

CAREGIVER NAME	CAREGIVER TELEPHONE NUMBER *(Include area code)*

IF THE VETERAN USES A WHEELCHAIR, CAN HE/SHE TRANSFER WITHOUT ASSISTANCE? ☐ YES ☐ NO

LIST ANY SPECIAL ASSISTIVE DEVICES THE VETERAN WILL BE USING

IF YES TO ANY ONE OF THE ABOVE QUESTIONS, EQUIPMENT MUST BE INSPECTED AND CERTIFIED BY THEIR SPONSORING MEDICAL FACILITY.

IS THE VETERAN ON PORTABLE OXYGEN? *(If yes, Rx i.e., 2L/min.)* ☐ YES ☐ NO

IS THE VETERAN ON CPAP/BIPAP? *(If yes, pressure setting)* ☐ YES ☐ NO

ATHLETES MUST BRING AND PROVIDE THEIR OWN CPAP/BIPAP

IF YES TO ANY ONE OF THE ABOVE QUESTIONS, SPONSORING VA MEDICAL CENTER MUST COORDINATE OXYGEN SERVICES, INCLUDING SUPPLIES AND EQUIPMENT, WITH A LOCAL OXYGEN PROVIDER.

LIST SPECIAL NEEDS *(e.g. feeding tube, tracheotomy, catheter, mobility, bowel and bladder care, etc.)*

LIST THOSE NEEDS WITH WHICH THE VETERAN REQUIRES ASSISTANCE

BEHAVIORAL NEEDS

COGNITIVE NEEDS

IF YES TO ANY ONE OF THE ABOVE QUESTIONS, ACCOMPANYING CAREGIVER MUST BE ABLE TO PROVIDE THE ASSISTANCE NEEDED.

WHAT ACTIVITY RESTRICTIONS DO YOU RECOMMEND?

THE VETERAN IS PHYSICALLY CAPABLE OF PARTICIPATING IN THESE HIGH RISK AEROBIC EVENTS

CYCLING	☐ YES	☐ NO
SWIMMING	☐ YES	☐ NO
TRACK	☐ YES	☐ NO

PLEASE SELECT THE EVENTS THE VETERAN CAN OR CANNOT PARTICIPATE IN

AIR RIFLE	☐ YES	☐ NO	HORSESHOES	☐ YES	☐ NO
BADMINTON	☐ YES	☐ NO	JAVELIN	☐ YES	☐ NO
BOWLING	☐ YES	☐ NO	NINE BALL	☐ YES	☐ NO
CHECKERS	☐ YES	☐ NO	SHOT PUT	☐ YES	☐ NO
DISCUS	☐ YES	☐ NO	SHUFFLEBOARD	☐ YES	☐ NO
DOMINOES	☐ YES	☐ NO	TABLE TENNIS	☐ YES	☐ NO
GOLF	☐ YES	☐ NO			

IN YOUR OPINION, CAN THE VETERAN MAKE THE TRIP AND PARTICIPATE IN THE NATIONAL VETERANS GOLDEN AGE GAMES? ☐ YES ☐ NO

DOES THE VETERAN HAVE AN ADVANCED DIRECTIVE? *(Attach copy)* ☐ YES ☐ NO

MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)? *(Attach copy)* ☐ YES ☐ NO

PROVIDER'S NAME *(Please print)*	☐ MD ☐ PA ☐ NP	
PROVIDER'S SIGNATURE	PROVIDER TELEPHONE NUMBER *(June 28 to July 1, 2014)*	PROVIDER PAGER NUMBER *(June 28 to July 1, 2014)*