

Athlete Medical Form



To be completed by Special Olympics

REGION:

DELEGATION/TEAM:

- MedFest@ Individual Physical
- Unified Partner (Medicals Optional) Healthy Young Athletes

ATHLETE INFORMATION

PARENT GUARDIAN INFORMATION

First Name: <input type="text"/>	Middle Name: <input type="text"/>	Name: <input type="text"/>
Last Name: <input type="text"/>	Phone: <input type="text"/>	Cell: <input type="text"/>
Date Birth (dd/mm/yyyy): <input type="text"/>	Female: <input type="checkbox"/> Male: <input type="checkbox"/>	E-mail: <input type="text"/>
Address: <input type="text"/>	Athlete's Primary Care Physician: <input type="text"/>	
Phone: <input type="text"/>	Cell: <input type="text"/>	Phone: <input type="text"/>
E-mail: <input type="text"/>	Eye color: <input type="text"/>	Primary Care Physician Address: <input type="text"/>

I am my own guardian. Yes No

Does the athlete have (check any that apply):

- Autism Down syndrome Fragile X Syndrome
- Cerebral Palsy Fetal Alcohol Syndrome
- Other syndrome, please specify:

List any sports the athlete wishes to play:

Is the athlete allergic to any of the following (please list):

- Food:
- Medications:
- Insect Bites or Stings:
- Latex No Known Allergies

Does the athlete use (check any that apply):

- Dentures Communication Device Wheel Chair
- Brace Removable Prosthetics Crutches or Walker
- Splint Glasses or Contacts Hearing Aid
- Pacemaker G-Tube or J-Tube Implanted Device
- Inhaler Colostomy C-PAP Machine

List all past surgeries:

List any special dietary needs:

List all ongoing or past medical conditions:

List all medical conditions that run in the athlete's family:

Does the athlete have any religious objections to medical treatment?

- No Yes *If yes, please complete the religious objections form.*

Has any relative died of a heart problem before age 40? No Yes

Has any family member or relative died while exercising? No Yes

Does the athlete currently have any chronic or acute infection?

- No Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG)?

- No Yes *If yes, please describe:*

Has a doctor ever limited the athlete's participation in sports? No Yes

If yes, please describe:

Has the athlete ever had an abnormal Echocardiogram (Echo)? No Yes

If yes, please describe:

Has the athlete had a Tetanus vaccine within the past 7 years? No Yes



Athlete's Name:

PLEASE INDICATE IF THE ATHLETE HAS EVER HAD ANY OF THE FOLLOWING CONDITIONS

- | | | | | | |
|--|--|---------------------|--|--------------------|--|
| Loss of Consciousness | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes | Stroke/TIA | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dizziness during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Cholesterol | <input type="checkbox"/> No <input type="checkbox"/> Yes | Concussions | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Headache during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | Vision Impairment | <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chest pain during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hearing Impairment | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Shortness of breath during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | Enlarged Spleen | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Irregular, racing or skipped heart beats | <input type="checkbox"/> No <input type="checkbox"/> Yes | Single Kidney | <input type="checkbox"/> No <input type="checkbox"/> Yes | Urinary Discomfort | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital Heart Defect | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteoporosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Spina Bifida | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Attack | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteopenia | <input type="checkbox"/> No <input type="checkbox"/> Yes | Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cardiomyopathy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sickle Cell Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heat Illness | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Valve Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sickle Cell Trait | <input type="checkbox"/> No <input type="checkbox"/> Yes | Broken Bones | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes | Easy Bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Endocarditis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Dislocated Joints | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

- Any difficulty controlling bowels or bladder No Yes
If yes, is this new or worse in the past 3 years? No Yes
- Numbness or tingling in legs, arms, hands or feet No Yes
If yes, is this new or worse in the past 3 years? No Yes
- Weakness in legs, arms, hands or feet No Yes
If yes, is this new or worse in the past 3 years? No Yes
- Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet No Yes
If yes, is this new or worse in the past 3 years? No Yes
- Head Tilt No Yes
If yes, is this new or worse in the past 3 years? No Yes
- Spasticity No Yes
If yes, is this new or worse in the past 3 years? No Yes
- Paralysis No Yes
If yes, is this new or worse in the past 3 years? No Yes
- Custom Item 1: No Yes

Please describe any past broken bones or dislocated joints:

Epilepsy or any type of seizure disorder No Yes

If yes, list seizure type:

Seizure during the past year? No Yes

Self-injurious behavior during the past year No Yes

Aggressive behavior during the past year No Yes

Depression No Yes

Anxiety No Yes

Please describe any additional mental health concerns:

Custom Item 2: No Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day

Is the athlete able to administer his or her own medications? No Yes If female, list the date of the athlete's last menstrual period:

Athlete Signature

Date

Legal Guardian Signature

Date



Athlete's Name:

Form C-1B

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

Height	Weight	Temperature	Pulse	O₂Sat	Blood Pressure	Vision
<input type="text"/> cm	<input type="text"/> kg	<input type="text"/> C	<input type="text"/>	<input type="text"/>	BP Right <input type="text"/> BP Left <input type="text"/>	<input type="text"/>
<input type="text"/> in	<input type="text"/> lbs	<input type="text"/> F				

Right Hearing (Finger Rub) Responds No Response Can't Evaluate Bowel Sounds No Yes
 Left Hearing (Finger Rub) Responds No Response Can't Evaluate Hepatomegaly No Yes
 Right Ear Canal Clear Cerumen Foreign Body Splenomegaly No Yes
 Left Ear Canal Clear Cerumen Foreign Body Abdominal Tenderness No RUQ RLQ LUQ LLQ
 Right Tympanic Membrane Clear Perforation Infection Kidney Tenderness No Right Left
 Left Tympanic Membrane Clear Perforation Infection Right upper extremity reflex Normal Diminished Hyperreflexia
 Oral Hygiene Good Fair Poor Left upper extremity reflex Normal Diminished Hyperreflexia
 Thyroid Enlargement No Yes Right lower extremity reflex Normal Diminished Hyperreflexia
 Lymph Node Enlargement No Yes Left lower extremity reflex Normal Diminished Hyperreflexia
 Heart Murmur (supine) No 1/6 or 2/6 3/6 or greater Abnormal Gait No Yes, describe
 Heart Murmur (upright) No 1/6 or 2/6 3/6 or greater Spasticity No Yes, describe
 Heart Rhythm Regular Irregular Tremor No Yes, describe
 Lungs Clear Not clear Neck & Back Mobility Full Not full, describe
 Right Leg Edema No 1+ 2+ 3+ 4+ Upper Extremity Mobility Full Not full, describe
 Left Leg Edema No 1+ 2+ 3+ 4+ Lower Extremity Mobility Full Not full, describe
 Radial Pulse Symmetry Yes R>L L>R Upper Extremity Strength Full Not full, describe
 Cyanosis No Yes, describe Lower Extremity Strength Full Not full, describe
 Clubbing No Yes, describe Loss of Sensitivity No Yes, describe

- Athlete does not have any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.
- Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and therefore must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

RECOMMENDATIONS (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete is deemed to need further medical evaluation please utilize the Special Olympics Further Medical Evaluation Form, page 4, in order to provide the athlete with medical clearance.

- This athlete is able to participate in Special Olympics sports. (Use Additional Licensed Examiner Notes for any restrictions or limitations).
- This athlete may not participate in Special Olympics sports at this time and must be evaluated by a physician for the following concerns:
 - Concerning Cardiac Exam
 - Acute Infection
 - O₂ Saturation Less than 90% on Room Air
 - Concerning Neurological Exam
 - Stage II Hypertension or Greater
 - Hepatomegaly or Splenomegaly

Other, please describe:

Additional Licensed Examiner's Notes:

- Follow up with a cardiologist
- Follow up with a neurologist
- Follow up with a primary care physician
- Follow up with a vision specialist
- Follow up with a hearing specialist
- Follow up with a dentist or dental hygienist
- Follow up with a podiatrist
- Follow up with a physical therapist
- Follow up with a nutritionist

Other:

Name:

E-mail:

Licensed Medical Examiner's Signature Date of Exam Phone: License:



Athlete's Name:

FURTHER MEDICAL EVALUATION FORM *(Only to be used if the athlete has previously not been cleared for sports participation above)*

Examiner's Name:

Examiner's Name:

Specialty:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete:
 Yes No May participate in Special Olympics sports (see below for restrictions or limitations)

In my professional opinion, this athlete:
 Yes No May participate in Special Olympics sports (see below for restrictions or limitations)

Additional Examiner Notes:

Additional Examiner Notes:

E-mail:

E-mail:

Phone:

Phone:

License:

License:

Examiner's Signature _____ Date _____

Examiner's Signature _____ Date _____

Examiner's Name:

Examiner's Name:

Specialty:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

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Please describe

In my professional opinion, this athlete:
 Yes No May participate in Special Olympics sports (see below for restrictions or limitations)

In my professional opinion, this athlete:
 Yes No May participate in Special Olympics sports (see below for restrictions or limitations)

Additional Examiner Notes:

Additional Examiner Notes:

E-mail:

E-mail:

Phone:

Phone:

License:

License:

Examiner's Signature _____ Date _____

Examiner's Signature _____ Date _____



Parent/Guardian

- o I am the parent/guardian of _____, the Athlete, on whose behalf I have completed the attached application for participation in Special Olympics. The Athlete has my permission to participate in Special Olympics activities.

Athlete

- o I, _____, am at least 18 years old and I have completed an application for participation in Special Olympics.

I further represent and warrant that to the best of my knowledge and belief, That _____ referred to herein as "the Athlete", is physically and mentally able to participate in Special Olympics. A licensed medical professional has reviewed the health information set forth in the Athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the Athlete's participation. I understand that if the licensed medical professional has detected symptoms that might result from spinal cord compression, including Atlanto-axial Instability, then the Athlete will only be permitted to participate in Special Olympics sports training and competition if the Athlete has a thorough neurological evaluation from a physician who certifies that the Athlete may participate and I have signed a consent acknowledging that I have been informed of the findings of the physician,

In permitting the Athlete to participate, I am specifically granting my permission, forever, to Special Olympics to use the Athlete's likeness, name, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

By signing below, I also permit the Athlete to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; podiatry; medicine; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand that notwithstanding my consent, there is no obligation for the Athlete to participate in the Healthy Athletes Program and that I may decide that the Athlete will not participate. I understand that provision of these health services is not intended as a substitute for regular care. I also understand that the Athlete should seek his/her own medical advice and assistance irrespective of the provision of these services and that Special Olympics, through providing these services, is not responsible for the Athlete's health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If a medical emergency should arise during the Athlete's participation in any Special Olympics activities, and I am not available or able to be consulted regarding the Athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the Athlete is provided with any emergency medical treatment, including hospitalization, that Special Olympics deems advisable in order to protect the Athlete's health and well-being. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT FORM)**

I am the Athlete or the parent and/or guardian of the Athlete named in this application. I have read and fully understand the provisions of the above release, and have explained the contents to the Athlete. Through my signature on this release form, I agree to the above provisions on my own behalf and on the behalf of the Athlete named above.

I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Guardian

Date

or

Signature of Athlete who signs on his or her own behalf

Date