Athlete Medical Form – **HEALTH HISTORY**

(pages 1 & 2 to be completed by the athlete or parent/guardian/caregiver)

Special Olympics

REGION/AREA:

DELEGATION/TEAM:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date Birth *(mm/dd/yyyy)* : Female: ☐ Male: ☐

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Eye color: Ethnicity: *(optional)*

Athlete Employer, if any:

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:

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

☐ Latex ☐ No Known Allergies

☐ Medications:

☐ Insect Bites or Stings:

☐ Food:

List any special dietary needs:

List all past surgeries:

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) or Echocardiogram (Echo)? *If yes, select below and describe*

☐ Yes, had abnormal EKG ☐ Yes, had abnormal Echo

☐ PARENT ☐ GUARDIAN INFORMATION *(if not own guardian)*

Name:

Phone: Cell:

E-mail:

Emergency Contact Name: Same as Above: ☐

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the athlete have a primary care physician? ☐ Yes ☐ No *If yes, list.*

Physician Name: Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?

☐ No ☐ Yes *If yes, contact your local Program to get the Emergency Care Refusal Form.*

List any sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

☐ No ☐ Yes *If yes, please describe:*

Does the athlete use *(check any that apply)*:

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

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

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes

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

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

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(pages 1 & 2 to be completed by athlete or parent/guardian/caregiver)

Athlete's Name:

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

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

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

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above)*:

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

If yes, list seizure type:

If yes, had 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 (diagnosed) ☐ No ☐ Yes

Anxiety (diagnosed) ☐ No ☐ Yes

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

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 athlete, list date of last menstrual period:**

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**

Athlete Medical Form – **PHYSICAL EXAM**
(to be completed by a Medical Professional only)

Athlete's Name:

MEDICAL PHYSICAL INFORMATION *(TO BE COMPLETED BY EXAMINER ONLY)*

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure	Vision
cm / in	kg / lbs	BMI / Body Fat %	C / F			BP Right: / BP Left:	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate				
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate				
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body				
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body				
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA			
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA			
Oral Hygiene	☐ Good	☐ Fair	☐ Poor				
Thyroid Enlargement	☐ No	☐ Yes					
Lymph Node Enlargement	☐ No	☐ Yes					
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater				
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater				
Heart Rhythm	☐ Regular	☐ Irregular					
Lungs	☐ Clear	☐ Not clear					
Right Leg Edema	☐ No	☐ 1+	☐ 2+	☐ 3+	☐ 4+		
Left Leg Edema	☐ No	☐ 1+	☐ 2+	☐ 3+	☐ 4+		
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R				
Cyanosis	☐ No	☐ Yes, describe					
Clubbing	☐ No	☐ Yes, describe					

Bowel Sounds	☐ Yes	☐ No					
Hepatomegaly	☐ No	☐ Yes					
Splenomegaly	☐ No	☐ Yes					
Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ	☐ LLQ		
Kidney Tenderness	☐ No	☐ Right	☐ Left				
Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia				
Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia				
Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia				
Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia				
Abnormal Gait	☐ No	☐ Yes, describe below					
Spasticity	☐ No	☐ Yes, describe below					
Tremor	☐ No	☐ Yes, describe below					
Neck & Back Mobility	☐ Full	☐ Not full, describe below					
Upper Extremity Mobility	☐ Full	☐ Not full, describe below					
Lower Extremity Mobility	☐ Full	☐ Not full, describe below					
Upper Extremity Strength	☐ Full	☐ Not full, describe below					
Lower Extremity Strength	☐ Full	☐ Not full, describe below					
Loss of Sensitivity	☐ No	☐ Yes, describe below					

ATLANTO-AXIAL INSTABILITY (AAI)

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings 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 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 needs further medical evaluation please use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance..

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions/limitations**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions/limitations** →

☐ **This athlete MAY NOT participate in Special Olympics sports at this time and MUST be further evaluated by a physician for the following concerns:**

☐ Concerning Cardiac Exam	☐ Acute Infection	☐ O_2 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 and Recommended Follow-up:

☐ 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/Exam Notes:

		Name:	
		E-mail:	
Licensed Medical Examiner's Signature	Date of Exam	Phone:	License:

Athlete Medical Form – **MEDICAL REFERRAL FORM**

(to be completed by a Medical Professional only if referral is needed)

Athlete's Name:

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates follow-up is required. Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:

Specialty:

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

In my professional opinion, this athlete MAY participate in Special Olympics sports (indicate restrictions or limitations below):

☐ **Yes, without restrictions** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail:

Examiner Phone:

License:

Examiner's Signature	**Date**

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? ☐ Yes ☐ No

The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete