

# 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:  Middle Name:

Last Name:

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

Address:

Phone:  Cell:

E-mail:  Eye color:

Name:

Phone:  Cell:

E-mail:

Athlete's Primary Care Physician:

Phone:

Primary Care Physician Address:

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	O <sub>2</sub> Sat	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"/>	<b>Right Vision</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
<input type="text"/>	in	<input type="text"/>	lbs	<input type="text"/>	F	<input type="text"/>	<input type="text"/>					<b>Left Vision</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds	<input type="checkbox"/> No	<input type="checkbox"/> Yes									
Left Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Hepatomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes									
Right Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Splenomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes									
Left Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Abdominal Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> RUQ	<input type="checkbox"/> RLQ	<input type="checkbox"/> LUQ	<input type="checkbox"/> LLQ						
Right Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection	Kidney Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> Right	<input type="checkbox"/> Left								
Left Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection	Right upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia								
Oral Hygiene	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Left upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia								
Thyroid Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Right lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia								
Lymph Node Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Left lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia								
Heart Murmur (supine)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Abnormal Gait	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe									
Heart Murmur (upright)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Spasticity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe									
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular		Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe									
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear		Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe									
Right Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+		Upper Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe									
Left Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+		Lower Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe									
Radial Pulse Symmetry	<input type="checkbox"/> Yes	<input type="checkbox"/> R>L <input type="checkbox"/> L>R		Upper Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe									
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe									
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> 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
  - O<sub>2</sub> 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:	<input type="text"/>
	E-mail:	<input type="text"/>
Licensed Medical Examiner's Signature	Date of Exam	Phone: <input type="text"/>
		License: <input type="text"/>



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)  
 Additional Examiner Notes:

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

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)  
 Additional Examiner Notes:

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

E-mail:

E-mail:

Phone:

Phone:

License:

License:

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_