Athlete Medical Form – **HEALTH HISTORY**

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

REGION/AREA:

DELEGATION/TEAM:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

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

Address @]bY %

Address @]bY &

Phone: Cell:

E-mail:

Eye color:

I am my own guardian. Yes No

☐ 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 haj Y a Primary care Physician: Yes No *If yes, list.*

Physician Name:

Physician Phone:

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.*

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 an abnormal Echocardiogram (Echo)? *If yes, select below and describe*
Yes, had abnormal EKG Yes, had abnormal Echo

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:

Athlete Medical Form – **HEALTH HISTORY**

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

Athlete's Name:

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

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

Condition		
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)*:

Condition		
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:

Athlete Signature *(if own guardian)* **Date**

Legal Guardian Signature *(only needed if not own guardian)* **Date**

Relationship to Athlete:

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 Cb`mcb		Vision
	cm		kg		BMI		C			BP Right:	BP Left:	**Right Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better
	in		lbs		Body Fat %		F					**Left Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better

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			

☐ **Athlete shows no evidence of 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 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 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** ☐ **No**

Additional Examiner Notes/Restrictions:

Physician E-mail:

Physician 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