Athlete Medical Form

Special Olympics

To be completed by Special Olympics

REGION: ________

DELEGATION/TEAM: ________

☐ MedFest® ☐ Individual Physical

☐ Unified Partner (Medicals Optional) ☐ Healthy Young Athletes

ATHLETE INFORMATION

First Name: ________ Middle Name: ________

Last Name: ________

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

Address: ________

Phone: ________ Cell: ________

E-mail: ________ Eye Color: ________

I am my own guardian. ☐ Yes ☐ No

☐PARENT ☐GUARDIAN INFORMATION

Name: ________

Phone: ________ Cell: ________

E-mail: ________

Athlete's Primary Care Physician: ________

Phone: ________

Address: ________

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, what were the findings?*

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, what were the findings?*

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

Condition	No	Yes
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 heart 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
Dislocated Joints	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

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

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:

PLEASE LIST ANY MEDICATIONS, VITAMINS OR DIETARY SUPPLEMENTS BELOW *(include 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:
Indicate date here

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_2 Sat	Blood Pressure	Vision
cm / in	kg / lbs	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	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 Medical 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_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:**

☐ 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 *If yes, please indicate why.*

Licensed Medical Examiner's Signature Date of Exam

Name:

E-mail:

Phone: License:

Athlete Name's:

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

Examiner's Name:

Specialty:

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:

E-mail:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

Specialty:

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:

E-mail:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

Specialty:

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:

E-mail:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

Specialty:

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:

E-mail:

Phone:

License:

Examiner's Signature Date