

Athlete Medical Form-Health History



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

County:

Organization:

ATHLETE INFORMATION

First Name: _____ Middle Name: _____
Last Name: _____
Date of Birth (mm/dd/yyyy): _____ Female: Male:
Address (Street): _____
Address (City, State, Zip): _____
Phone: _____ Cell: _____
E-mail: _____
Eye color: _____ Ethnicity: _____
(voluntary)
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 an abnormal 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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Athlete's name

Special Olympics
Ohio



Athlete's Name:

INDICATE IF THE ATHLETE HAS 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
<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Numbness or tingling in legs, arms, hands or feet	No	Yes
<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Weakness in legs, arms, hands or feet	No	Yes
<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	No	Yes
<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Head Tilt	No	Yes
<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Spasticity	No	Yes
<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Paralysis	No	Yes
<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes

Describe any past broken bones or dislocated joints <i>(if yes is checked for either of those fields above):</i>		
Epilepsy or any type of seizure disorder	No	Yes
<i>If yes, list seizure type:</i>		
<i>If yes, had seizure during the past year?</i>	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)*

Relationship to Athlete:

Date



ATHLETE RELEASE FORM

I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.
2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.
3. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:
 - I have a religious or other objection to receiving medical treatment.
 - I consent to emergency medical care, but I do not consent to blood transfusions.(If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.
6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
 - Make sure I am eligible and can participate safely;
 - Run trainings and events and share results;
 - Put my information in a computer system;
 - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
 - Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publically); and
 - Protect health and safety, respond to government requests, and report information required by law.I can ask to see and revise my information. I can ask to limit how my information is used.
7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

PARTICIPANT NAME: _____

PARTICIPANT SIGNATURE (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required if under 18 years old or has a legal guardian)

I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Athlete Medical Form-Physical Examination

(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 ₂ Sat	Blood Pressure		Vision	
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 20/40 or better	
in	lbs	Body Fat %	F					Left Vision <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 20/40 or better	
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
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 <input type="checkbox"/> NA	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 <input type="checkbox"/> NA	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 below			
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 below			
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular		Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below			
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear		Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below			
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 below			
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 below			
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 below			
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below			
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> 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:

<input type="checkbox"/> Concerning Cardiac Exam	<input type="checkbox"/> Acute Infection	<input type="checkbox"/> O ₂ Saturation Less than 90% on Room Air
<input type="checkbox"/> Concerning Neurological Exam	<input type="checkbox"/> Stage II Hypertension or Greater	<input type="checkbox"/> Hepatomegaly or Splenomegaly
<input type="checkbox"/> Other, please describe:		

Additional Licensed Examiner's Notes and Recommended Follow-up:

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

		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)

Special Olympics
Ohio



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:

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