Special Olympics Kansas

Dear Parent, Athlete or Friend:

Welcome to Special Olympics Kansas! Thank you for taking time to enroll someone you care about in Special Olympics.

Special Olympics is a year-round program of sports training, education, and competition for persons with intellectual disabilities, age eight years and older. The goal of the program is to provide continuing opportunities for the athletes to develop physical fitness, demonstrate courage, experience joy and participate in the sharing of skills and friendship with their families, other athletes and the community.

Enclosed in this Athlete Enrollment Kit is the information and forms you will need to register your athlete for participation in Special Olympics.

Through Special Olympics, athletes gain self-esteem, confidence and discipline, which carry over into other aspects of their lives. For additional information about Special Olympics Kansas, please visit our web site at www.ksso.org.

We look forward to welcoming your athlete into our Special Olympics Kansas family.

Sincerely,

John M. Lair
President & CEO

Special Olympics Kansas
5280 Foxridge Drive, Mission, KS 66202 **Tel** 913 236 9290 **Fax** 913 236 9771
Email kso@ksso.org **Facebook** @specialolympicskansas **Twitter** @sokansas
www.ksso.org

Special Olympics Kansas
Athlete Enrollment

Steps to Becoming a registered Special Olympics Kansas athlete:

1. Complete the **Athlete Registration Paperwork.**

   A parent/guardian or adult athlete must sign the release statement.

2. Complete the **Special Olympics Kansas Medical Form**.

3. Arrange for a physical examination and your athlete's medical history to be completed. This can be completed by your regular Physician, a Medical Doctor, Doctor of Osteopathy, Doctor of Chiropractic, Physician's Assistant or Advanced Registered Nurse Practitioner (ARNP). Some Physicians will perform the necessary examination for free or at reduced cost when asked to do so for Special Olympics.

   Special Olympics Kansas does accept school physicals or similar physical exam/medical releases that clearly state the athlete is cleared to participate in physical activity and is signed by a medical professional.

4. Keep a copy of all the forms for yourself.

5. Send all of completed original forms to the Special Olympics Kansas Headquarters Office:

   Special Olympics Kansas
   5280 Foxridge Drive
   Mission, KS 66202

   Fax: 913-236-9771

   Email: johnsonm@ksso.org

6. Once the enrollment forms are completed and received by SOKS the registered athlete is eligible to compete at the local, regional, and state events. SOKS will provide contact information for local teams if required.

Special Olympics Kansas
Athlete Enrollment

Definition of Eligibility Statement

General Statement of Eligibility. Special Olympics training and competition is open to every person with intellectual disabilities who is at least eight years of age and who registers to participate in Special Olympics.

Age Requirements. There is no maximum age limitation for participation in Special Olympics. Special Olympics Kansas permits children who are at least six years old to participate in soccer skills, basketball skills and low motor track activities at the regional level; however, each Local Program has the discretion to decide what sports they choose to offer. No child may participate in a Special Olympics competition (or be awarded medals or ribbons associated with competition) before his or her eighth birthday.

Degree of Disability. Participation in Special Olympics training and competition is open to all persons with intellectual disabilities who meet the age requirements, regardless of the level or degree of that person's disability, and whether or not that person also has other mental or physical disabilities, so long as that person registers to participate in Special Olympics.

Eligibility Criteria. A person is considered to have intellectual disabilities for purposes of determining his or her eligibility to participate in Special Olympics if that person satisfies any one of the following requirements:

(1) The person has been identified by an agency or professional as having intellectual disabilities as determined by their localities; or

(2) The person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted within the professional community as being a reliable measurement of the existence of a cognitive delay; or

(3) The person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as recreation, work, independent living, self-direction, or self-care). However, persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes.

Preserving Flexibility in Identifying Eligible Athletes. SOKS may depart from the eligibility requirements identified above if there are exceptional circumstances which warrant such a departure. **Any questions related to an athlete's eligibility on a secondary school team should be referred to the Kansas State High School Activities Association, (785) 273-5329.**

ATHLETE REGISTRATION

Special Olympics

Dear Special Olympics Kansas Athletes, Parents, and Guardians:

Through the power of sports, our athletes find joy, confidence and fulfillment — on the playing field and in life. Whether you are new to Special Olympics or have been involved for years, we are excited you are part of the movement!

FORMS TO BE COMPLETED ONCE BY NEW OR RETURNING ATHLETES

Athletes that are new to the program or returning (inactive two years or more) must complete these forms. These forms only need to be completed once ever as long as the athlete remains active (participates at least once every two years):

☐ **REGISTRATION FORM.** This form asks for contact and other information.

☐ **RELEASE FORM.** This form goes over some important details about Special Olympics participation.

☐ **LIKENESS RELEASE FOR SPONSORS.** Allows for Special Olympics sponsors to use your photos, videos and stories, you may choose to sign this form.

☐ **COMMUNICABLE DISEASES WAIVER** – Required for all Athletes, Coaches, Unified Partners and Program Volunteers prior to attending an in-person practice or competition.

MEDICAL FORM (COMPLETED ON A REGULARLY SCHEDULED BASIS)

☐ **MEDICAL FORM.**

- **Health History** (Page 1-2) – Required to be completed by the athlete or parent/guardian/caregiver upon initial registration. This form is not required to be completed on a regular basis if there are no material changes to the athletes health or medications. A Local Program may require this within their discretion.
- **Physical Exam** (Page 3) – This form is designed to identify health concerns that are more common among people with intellectual disabilities and clear an athlete to participate. The Physical Exam section on page 3 should be filled out and signed by a licensed medical professional (for example, Physician, Registered Nurse Practitioner, or Physician Assistant). AREAS INDICATED BY A STAR MUST BE COMPLETED TO BE ACCEPTED.
- **Medical Referral Form** (Page 4) – Only needed if the athlete is not cleared by a licensed medical professional and additional evaluation is required.

The Special Olympics Medical Form may be current for up to three years. The renewal period will begin January 1 of a cycle and all Medical/Release Forms submitted during the renewal period or during the cycle will expire on December 31 of 2022, 2024, etc. A Medical Form may be submitted to Headquarters at any time.

Physicals Given Between	***Expire***
January 1, 2020 – December 31, 2021	December 31, 2022
January 1, 2022 – December 31, 2023	December 31, 2024
January 1, 2024 – December 31, 2025	December 31, 2026

The Release Form and the Medical Form instruct you to complete other forms in certain uncommon situations. If this applies to you or if you have any other questions, please contact Michele Johnson at johnsonm@ksso.org or 913-236-9290 ext 105.

Please submit registration and medical forms to your Regional Director or the SOKS state office.

FAQ

What has changed?

The SOKS medical/release form that we had been using was out of date and it was time to move to the official Special Olympics form. Our old form had been approved by SOI insurance but there were some missing elements now required by Special Olympics that we felt it was simply time to move to the official form instead of trying to make the necessary updates to our old one. We need to make sure that we are staying in compliance with the SOI insurance for liability reasons.

In some ways this is now simpler for the program, as the release portion of the form only has to be completed once for active athletes and does not need to be completed each time the medical expires.

Do current, active athletes need to do the Registration Form paperwork?

No. We have determined that what is captured in the old medical/release paperwork while not as comprehensive as the new registration paperwork, is sufficient and we do not want to put that extra burden on Local Programs.

Will Special Olympics Kansas still accept medicals from other organizations (i.e. KSHSAA)?

Yes, as long as it's clear on the form that a medical professional is signing off on participation and there is a signature.

We still need our release forms signed (once) but will continue to accept third party medicals.

How often do we need to complete the registration form?

This only needs to be done once as long as the athlete remains active. If an athlete is inactive for two or more years, we do need an updated form on-file.

How often do we need to complete the release form?

This only needs to be done once as long as the athlete remains active. If an athlete is inactive for two or more years, we do need an updated form on-file.

What has to be completed as part of the medical form?

Page 3 of the Medical Form is absolutely required to be up to date and we will not accept it if the athlete's name is not on the form and the three boxes highlighted in red are not completed by a medical professional. These three boxes are the Spinal Cord Compression & AAI, Athlete Clearance to Participate and the Signature by a Licensed Medical Examiner.

How about the Health Information Update form?

We will no longer accept the Health Information Update form. A new Medical form must be completed.

ATHLETE REGISTRATION FORM

Special Olympics

State Special Olympics Program:_____ **Local Area/Delegation:**_____

Are you a new athlete to Special Olympics or Re-Registering? New Athlete Re-Registering

ATHLETE INFORMATION		
First Name:	**Middle Name:**	
Last Name:	**Preferred Name:**	
Date of Birth (mm/dd/yyyy):	Female Male Other Gender Identity	
Race/Ethnicity: Prefer not to answer American Indian/Alaskan Native Asian American More than one race Black or African American Native Hawaiian or Other Pacific Islander White or Caucasian Hispanic or Latinx		
Language(s) Spoken in Athlete's Home (Optional): Check all that apply English Spanish Other (please list):		
Street Address:		
City:	**State:**	**Zip Code:**
Phone:	**E-mail:**	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? Yes No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
Same Contact Info as Athlete		
Street Address:		
City:	**State:**	**Zip Code:**
Phone:	**E-mail:**	
EMERGENCY CONTACT INFORMATION		
Same as Parent/Guardian		
Name:		
Phone:	**Relationship:**	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

ATHLETE LIKENESS RELEASE FOR SPONSORS (OPTIONAL)

Special Olympics

Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below.

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use my likeness, photo, video, name, voice, words, and biographical information ("my likeness") to acknowledge the sponsors' and partners' support for Special Olympics.
- Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
- I understand I will not be compensated for the use of my Likeness.

Athlete Name:	
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**

ATHLETE RELEASE FORM

Special Olympics

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

   I have a religious or other objection to receiving medical treatment. (Not common.)
   I do not consent to blood transfusions. (Not common.)
   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
   - I agree and consent to Special Olympics:
     - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
     - using my contact information for communicating with me about Special Olympics.
     - sharing my personal information confidentially with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
   - *Privacy Policy.* Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

Athlete Name:	
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**

CONCUSSION AWARENESS AND SAFETY RECOGNITION POLICY

Objective

It is Special Olympics' intent to take steps to help ensure the health and safety of all Special Olympics participants. All Special Olympics participants should remember that safety comes first and should take reasonable steps to help minimize the risks for concussion or other serious brain injuries.

Defining a Concussion

A concussion is defined by the Centers for Disease Control as a type of traumatic brain injury caused by a bump, blow, or jolt to the head as well as serial, cumulative hits to the head. Concussions can also occur from a blow to the body that causes the head and brain to move quickly back and forth—causing the brain to bounce around or twist within the skull. Although concussions are usually not life-threatening, their effects can be serious and therefore proper attention must be paid to individuals suspected of sustaining a concussion.

Suspected or Confirmed Concussion

A participant who is suspected of sustaining a concussion in a practice, game or competition shall be removed from practice, play or competition at that time. If a qualified medical professional is available on-site to render an evaluation, that person shall have final authority as to the removal or return to play of the participant. If applicable, the participant's parent or guardian should be made aware that the participant is suspected of sustaining a concussion.

Return to Play

A participant who has been removed from practice, play or competition due to a suspected concussion may not participate in Special Olympics sports activities until either of the following occurs (1) at least seven (7) consecutive days have passed since the participant was removed from play and a currently licensed, qualified medical professional provides written clearance for the participant to return to practice, play and competition or (2) a currently licensed, qualified medical professional determines that the participant did not suffer a concussion and provides written clearance for the participant to return to practice play immediately. Written clearance in either of the scenarios above shall become a permanent record.

The Centers for Disease Control website www.cdc.gov/concussion provides additional resources relative to concussions that may be of interest to participants and their families.

Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Special Olympics

Athlete First & Last Name:_____ **Preferred Name:**_____

Athlete Date of Birth (mm/dd/yyyy):_____ ☐ Female ☐ Male ☐ Other Gender Identity

STATE PROGRAM:_____ **E-mail:**_____

ASSOCIATED CONDITIONS - **Does the athlete have** *(check any that apply)*:

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ Other Syndrome, please specify:_____

ALLERGIES & DIETARY RESTRICTIONS

☐ No Known Allergies
☐ Latex
☐ Medications:_____
☐ Insect Bites or Stings:_____
☐ Food:_____

ASSISTIVE DEVICES - **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

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?
☐ No ☐ Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

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, describe date and results*
☐ Yes, had abnormal EKG
☐ Yes, had abnormal Echo

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

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

*If yes, list seizure type:*_____

If yes, had seizure during the past year? ☐ No ☐ Yes

MENTAL HEALTH

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:

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**

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)

Athlete's First and Last 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				

If female athlete, list date of last menstrual period:_____

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

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

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 LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

★

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

Athlete Medical Form – **PHYSICAL EXAM**

(To be completedyba Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name:_____ **Date of Birth**_____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

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

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

OR

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

ATHLETE CLEARANCE TO PARTICIPATE (*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 make a referral below and second physician for referral should complete page 4.

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

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe →** _____

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

- ☐ Concerning Cardiac Exam
- ☐ Concerning Neurological Exam
- ☐ Other, please describe:
- ☐ Acute Infection
- ☐ Stage II Hypertension or Greater
- ☐ O_2 Saturation Less than 90% on Room Air
- ☐ Hepatomegaly or Splenomegaly

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ 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
- ☐ Other/Exam Notes:

Name:

E-mail:

Signature of Licensed Medical Examiner Exam Date Phone: License #:

Athlete Medical Form – **MEDICAL REFERRAL FORM**

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

Athlete's First and Last Name:_____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:_____

Specialty:_____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

☐ 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:

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

☐ **Yes** ☐ **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