# 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 | $O_2$Sat | 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