

Athlete Medical Form

Special
Olympics

To be completed by Special Olympics

REGION: MedFest® Individual PhysicalDELEGATION/TEAM: Unified Partner
(Medicals Optional) Healthy Young Athletes

ATHLETE INFORMATION

 PARENT GUARDIAN INFORMATIONFirst Name: Middle Name: Name: Last Name: Phone: Cell: Date of Birth (dd/mm/yyyy) / / Female: Male: E-mail: Address: Athlete's Primary Care Physician: Phone: Cell: Phone: E-mail: Eye Color: Address: 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:

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

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

					Blood Pressure		Vision		
cm	kg	C					No	Yes	N/A
in	lbs	F					No	Yes	N/A
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
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	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	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			
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			
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular		Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe			
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear		Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe			
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			
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			
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			
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe			
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> 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
 - O₂ 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 <input style="width: 100%;" type="text"/>	Name: <input style="width: 100%;" type="text"/>	E-mail: <input style="width: 100%;" type="text"/>
		Phone: <input style="width: 100%;" type="text"/>	License: <input style="width: 100%;" type="text"/>

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: Examiner's Name:

Specialty: Specialty:

I have examined this athlete for the following medical concern(s):

Please describe

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:

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:

E-mail:

Phone:

Phone:

License:

License:

Examiner's Signature Date

Examiner's Signature Date

Examiner's Name: Examiner's Name:

Specialty: Specialty:

I have examined this athlete for the following medical concern(s):

Please describe

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:

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:

E-mail:

Phone:

Phone:

License:

License:

Examiner's Signature Date

Examiner's Signature Date