

Athlete Medical Form

Special Olympics
Texas



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NEW RENEWAL UPDATE

Area	Delegation Code	Delegation Name
<input type="radio"/> Individual Physical <input type="radio"/> MedFest® <input type="radio"/> Unified Partner (<i>medical's optional</i>) <input type="radio"/> Healthy Young Athletes		

ATHLETE INFORMATION

Last Name	First Name	
Middle Name	Nickname	
Date of Birth ___/___/____ MM/DD/YYYY	Gender <input type="radio"/> Male <input type="radio"/> Female	Eye Color
Address	City/State/Zip	
Home Phone ()	Cell Phone ()	
Email	I am my own guardian. <input type="radio"/> Yes <input type="radio"/> No	
Employer	Employer's Phone	
Employer's Address	City/State/Zip	
Sports the athlete is interested in playing:		

PARENT/GUARDIAN INFORMATION

Relationship to Athlete	
Last Name	First Name
Home Phone ()	Cell Phone ()
Address	City/State/Zip
Email	
Employer	Employer's Phone
Employer's Address	City/State/Zip

ATHLETE MEDICAL INFORMATION

Primary Care Physician	Physician's Phone ()
Physician's Address	City/State/Zip
The athlete has (<i>check all that apply</i>) <input type="radio"/> Autism <input type="radio"/> Down Syndrome <input type="radio"/> Fragile X Syndrome <input type="radio"/> Cerebral Palsy <input type="radio"/> Fetal Alcohol Syndrome <input type="radio"/> Other syndrome (<i>please specify</i>):	
The athlete uses (<i>check any that apply</i>) <input type="radio"/> Dentures <input type="radio"/> Communication Device <input type="radio"/> Wheelchair <input type="radio"/> Brace <input type="radio"/> Removable Prosthetics <input type="radio"/> Crutches or Walker <input type="radio"/> Splint <input type="radio"/> Glasses or Contacts <input type="radio"/> Hearing Aid <input type="radio"/> Pacemaker <input type="radio"/> G-Tube or J-Tube <input type="radio"/> Implanted Device <input type="radio"/> Inhaler <input type="radio"/> Colostomy <input type="radio"/> C-PAP Machine	
Athlete's Allergies (<i>please list</i>) <input type="radio"/> No Known Allergies <input type="radio"/> Latex <input type="radio"/> Insect Bites or Stings: <input type="radio"/> Food: <input type="radio"/> Medications:	
Special Dietary Needs	
Does the athlete have any religious objections to medical treatment? <input type="radio"/> No <input type="radio"/> Yes <i>If yes, please complete the religious objections form.</i>	
Does the athlete currently have any chronic or acute infection? <input type="radio"/> No <input type="radio"/> Yes <i>If yes, please describe:</i>	

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Athlete Last Name	Athlete First Name
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ATHLETE MEDICAL HISTORY

List all past surgeries:

List all ongoing or past medical conditions:

List all medical conditions that run in the athlete's family:

Has any relative died of a heart problem before age 40? No Yes Has any relative died while exercising? No Yes

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

Has the athlete ever had an abnormal Electrocardiogram (EKG)? No Yes *If yes, please describe:*

Has the athlete ever had an abnormal Echocardiogram (Echo)? No Yes *If yes, please describe:*

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

PLEASE INDICATE IF THE ATHLETE HAS EVER HAD ANY OF THE FOLLOWING CONDITIONS

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

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:

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Athlete Last Name	Athlete First Name
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MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS (includes inhalers, birth control or hormone therapy)					
Name of Medication	Dosage	Times per Day	Name of Medication	Dosage	Times per Day
Is the athlete able to administer his/her own medications? <input type="radio"/> No <input type="radio"/> Yes			If female, date of athlete's last menstrual period:		

PLEASE READ BEFORE SIGNING

It is understood and agreed that: If the examiner is provided free of charge, it is not intended to be a thorough or comprehensive examination. No physician-patient relationship is to arise out of the examination. The doctor, nurse or other person involved in the examination is under no obligation to provide a diagnosis, treatment, advice, consultation or any follow-up care whatsoever under any circumstances. The fact that any person is cleared or authorized to participate in any sport or other activity does not mean and is not to be interpreted as the opinion of the doctor or nurse that the person examined is healthy, in need of no care, or can participate in any sport or other activity without serious medical risks. Any claim against the doctor, nurse or other person involved in the examination will be submitted to binding arbitration pursuant to the rules and procedures of the American Arbitration Association. The person examined and any person who signs on his or her behalf promises to indemnify the doctor or nurse from any and all damages, claims, or losses, including injury or death that allegedly arise out of or are in any way related to the examination.

Participation: I hereby give my permission for the participant named above to participate in any Special Olympics activity or event of any kind. I understand that participation at local or area competition does not guarantee advancement to State or World Games. Athletes must be registered using this release form prior to any athlete training.

Medical: I represent and warrant to you that the athlete is physically and mentally able to participate in Special Olympics Texas.

Disclaimer: On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release the physicians, organizers, officers, directors, agents or employees of Special Olympics Texas from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or the athlete.

Hospitalization: If I am not personally present at the event in which the athlete is to compete so as to be consulted in case of emergency, you are authorized on my behalf and at my account to take such measure and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete.

Media: In permitting the athlete to participate, I am specifically granting permission to you to use the name, likeness, voice, words, and biographical information of the athlete in television, radio, films, newspapers, magazines, web pages and other media, and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of Special Olympics Texas and in appealing for funds to support such activities.

SOTX Housing Policy: For any overnight trip, a gender-specific athlete to chaperone ratio of 4 to 1 is required (see SIG section N for specific breakdown). No athletes or volunteers of opposite genders may room together. The only exceptions are: if the athletes/volunteers are married; or if a family member of the opposite gender is chaperoning. Unified Partners under the age of 17 should be included in the ratio as in need of a chaperone.

ATHLETE OR PARENT/GUARDIAN SIGN AND DATE	
Printed Name	Check One: <input type="radio"/> Parent <input type="radio"/> Guardian <input type="radio"/> Athlete (if over the age of 18)
Signature	Date

Athlete Physical

TO BE COMPLETED BY MEDICAL EXAMINER ONLY

Special Olympics
Texas



Athlete Last Name	Athlete First Name
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ATHLETE MEDICAL PHYSICAL INFORMATION

Height _____ cm _____ in	Weight _____ kg _____ lbs	Temp _____ °C _____ °F	Pulse	O ₂ Sat
Blood Pressure: BP Right		Blood Pressure: BP Left		
Right Vision: 20/40 or better? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> N/A		Left Vision: 20/40 or better? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> N/A		
Right Hearing (Finger Rub) <input type="radio"/> Responds <input type="radio"/> No Response <input type="radio"/> Can't Evaluate	Left Hearing (Finger Rub) <input type="radio"/> Responds <input type="radio"/> No Response <input type="radio"/> Can't Evaluate	Bowel Sounds <input type="radio"/> No <input type="radio"/> Yes	Hepatomegaly <input type="radio"/> No <input type="radio"/> Yes	
Right Ear Canal <input type="radio"/> Clear <input type="radio"/> Cerumen <input type="radio"/> Foreign Body	Left Ear Canal <input type="radio"/> Clear <input type="radio"/> Cerumen <input type="radio"/> Foreign Body	SplenoMegaly <input type="radio"/> No <input type="radio"/> Yes	Abdominal Tenderness <input type="radio"/> No <input type="radio"/> RUQ <input type="radio"/> RLQ <input type="radio"/> LUQ <input type="radio"/> LLQ	
Right Tympanic Membrane <input type="radio"/> Clear <input type="radio"/> Perforation <input type="radio"/> Infection	Left Tympanic Membrane <input type="radio"/> Clear <input type="radio"/> Perforation <input type="radio"/> Infection	Kidney Tenderness <input type="radio"/> No <input type="radio"/> Right <input type="radio"/> Left	Right upper extremity reflex <input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Hyperreflexia	
Oral Hygiene <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	Thyroid Enlargement <input type="radio"/> No <input type="radio"/> Yes	Left upper extremity reflex <input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Hyperreflexia	Right lower extremity reflex <input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Hyperreflexia	
Lymph Node Enlargement <input type="radio"/> No <input type="radio"/> Yes	Heart Murmur (supine) <input type="radio"/> No <input type="radio"/> 1/6 or 2/6 <input type="radio"/> 3/6 or greater	Left lower extremity reflex <input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Hyperreflexia	Abnormal Gait <input type="radio"/> No <input type="radio"/> Yes, describe	
Heart Murmur (upright) <input type="radio"/> No <input type="radio"/> 1/6 or 2/6 <input type="radio"/> 3/6 or greater	Heart Rhythm <input type="radio"/> Regular <input type="radio"/> Irregular	Spasticity <input type="radio"/> No <input type="radio"/> Yes, describe	Tremor <input type="radio"/> No <input type="radio"/> Yes, describe	
Lungs <input type="radio"/> Clear <input type="radio"/> Not clear	Right Leg Edema <input type="radio"/> No <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+	Neck & Back Mobility <input type="radio"/> Full <input type="radio"/> Not full, describe	Upper Extremity Mobility <input type="radio"/> Full <input type="radio"/> Not full, describe	
Left Leg Edema <input type="radio"/> No <input type="radio"/> 1+ <input type="radio"/> 2+ <input type="radio"/> 3+ <input type="radio"/> 4+	Radial Pulse Symmetry <input type="radio"/> Yes <input type="radio"/> R>L <input type="radio"/> L>R	Lower Extremity Mobility <input type="radio"/> Full <input type="radio"/> Not full, describe	Upper Extremity Strength <input type="radio"/> Full <input type="radio"/> Not full, describe	
Cyanosis <input type="radio"/> No <input type="radio"/> Yes, describe	Clubbing <input type="radio"/> No <input type="radio"/> Yes, describe	Lower Extremity Strength <input type="radio"/> Full <input type="radio"/> Not full, describe	Loss of Sensitivity <input type="radio"/> No <input type="radio"/> 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

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 next page: Special Olympics Further Medical Evaluation Form, in order to provide the athlete with medical clearance.

YES - This athlete is able to participate in Special Olympics sports. (Use Additional Licensed Examiner's Notes for any restrictions or limitations).

NO - This athlete may **not** participate in Special Olympics sports at this time and must be evaluated by a physician for the following concerns:

<input type="radio"/> Concerning Cardiac Exam	<input type="radio"/> Acute Infection	<input type="radio"/> O ₂ Saturation Less than 90% on Room Air
<input type="radio"/> Concerning Neurological Exam	<input type="radio"/> Stage II Hypertension or Greater	<input type="radio"/> Hepatomegaly or SplenoMegaly

Other, please describe:

Additional Licensed Examiner Notes:

<input type="radio"/> Follow up with a cardiologist	<input type="radio"/> Follow up with a neurologist	<input type="radio"/> Follow up with a primary care physician
<input type="radio"/> Follow up with a vision specialist	<input type="radio"/> Follow up with a hearing specialist	<input type="radio"/> Follow up with a dentist or dental hygienist
<input type="radio"/> Follow up with a podiatrist	<input type="radio"/> Follow up with a physical therapist	<input type="radio"/> Follow up with a nutritionist

Other, please describe:

MEDICAL EXAMINER SIGN AND DATE

Signature of Licensed Physician, Physician's Assistant licensed by State Board of Physicians Assistant Examiners, or Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.	Date of Exam
Printed Name	Email
Phone ()	License

Further Medical Evaluation Form

ONLY TO BE USED IF THE ATHLETE HAS PREVIOUSLY NOT BEEN CLEARED FOR SPORTS PARTICIPATION ON THE PREVIOUS PAGE

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Athlete Last Name	Athlete First Name
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FURTHER MEDICAL EVALUATION	
Examiner's Name	Specialty
I have examined this athlete for the following medical concern(s): <i>Please describe.</i>	
<input type="radio"/> YES <input type="radio"/> NO In my professional opinion, this athlete may participate in Special Olympics sports (see below for restrictions or limitations).	
Additional Licensed Examiner Notes:	
Signature	Date
Printed Name	Email
Phone ()	License

FURTHER MEDICAL EVALUATION	
Examiner's Name	Specialty
I have examined this athlete for the following medical concern(s): <i>Please describe.</i>	
<input type="radio"/> YES <input type="radio"/> NO In my professional opinion, this athlete may participate in Special Olympics sports (see below for restrictions or limitations).	
Additional Licensed Examiner Notes:	
Signature	Date
Printed Name	Email
Phone ()	License

FURTHER MEDICAL EVALUATION	
Examiner's Name	Specialty
I have examined this athlete for the following medical concern(s): <i>Please describe.</i>	
<input type="radio"/> YES <input type="radio"/> NO In my professional opinion, this athlete may participate in Special Olympics sports (see below for restrictions or limitations).	
Additional Licensed Examiner Notes:	
Signature	Date
Printed Name	Email
Phone ()	License