

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:

Athlete Medical Form-Health History

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

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

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 publicly); 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*)

Special Olympics

Ohio



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

☐ 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:		

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

- | | | |
|---|--|---|
| ☐ 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/Exam Notes: | | |

		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