Athlete Medical Form

Special Olympics

AREA: ☐ MedFest® ☐ Individual Physical

COACHES NAME: ☐ Unified Partner (Medicals Optional) ☐ Healthy Young Athletes

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date of Birth (dd/mm/yyyy) Female: ☐ Male: ☐

Address:

Phone: Cell:

E-mail: Eye Color:

I am my own guardian. ☐ Yes ☐ No

☐PARENT ☐GUARDIAN INFORMATION

Name:

Phone: Cell:

E-mail:

Athlete's Primary Care Physician:

Phone:

Address:

Aware of Concussion Policy ☐ Aware of Housing Policy ☐

*both policies can be found at www.specialolympicsarkansas.org

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

Has the athlete ever had an abnormal Electrocardiogram (EKG)?

☐ No ☐ Yes

Has a doctor ever limited the athlete's participation in sports?

☐ No ☐ Yes

Has the athlete ever had an abnormal Echocardiogram (Echo)?

☐ No ☐ Yes

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	☐ 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			
Endocarditis	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ 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: _____

Athlete Signature _____ Date _____

Legal Guardian Signature _____ Date _____

Athlete's Name: _____

Form C-1B

MEDICAL PHYSICAL INFORMATION *(TO BE COMPLETED BY EXAMINER ONLY)*

Height	Weight	Temperature	Pulse	O_2 Sat	Blood Pressure	Vision
☐ cm ☐ in	☐ kg ☐ lbs	☐ C ☐ F			BP Right ☐ BP Left ☐	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	Bowel Sounds	☐ No	☐ Yes	
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	Kidney Tenderness	☐ No	☐ Right	☐ Left
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	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	
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	Spasticity	☐ No	☐ Yes, describe	
Heart Rhythm	☐ Regular	☐ Irregular		Tremor	☐ No	☐ Yes, describe	
Lungs	☐ Clear	☐ Not clear		Neck & Back Mobility	☐ Full	☐ Not full, describe	
Right Leg Edema	☐ No	☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+		Upper Extremity Mobility	☐ Full	☐ Not full, describe	
Left Leg Edema	☐ No	☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+		Lower Extremity Mobility	☐ Full	☐ Not full, describe	
Radial Pulse Symmetry	☐ Yes	☐ R>L ☐ L>R		Upper Extremity Strength	☐ Full	☐ Not full, describe	
Cyanosis	☐ No	☐ Yes, describe		Lower Extremity Strength	☐ Full	☐ Not full, describe	
Clubbing	☐ No	☐ Yes, describe		Loss of Sensitivity	☐ No	☐ 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 ☐ 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:**

☐ 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 _____

Licensed Medical Examiner's Signature Date of Exam _____

Name: _____
E-mail: _____
Phone: _____ License: _____

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:

Specialty:

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

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:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

Specialty:

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

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:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

Specialty:

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

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:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

Specialty:

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

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:

Phone:

License:

Examiner's Signature Date