

Athlete Medical Form-Health History



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

County

Organization

ATHLETE INFORMATION

PARENT GUARDIAN INFORMATION (if not own guardian)

First Name _____ Middle Name: _____
 Last Name _____
 Date of birth month/day/year: _____ Female Male

Name: _____
 Phone: _____ Cell: _____
 E-mail: _____

Address (Street)

Emergency Contact Name: _____ Same as Above: _____

Address (City, State, Zip):

Emergency Contact Phone (cell):

Phone: _____ Cell: _____

Emergency Contact Relationship:

E-mail:

Does the Athlete have a Primary care Physician: Yes No *If yes, list*

Eye color: _____ Ethnicity: _____
(voluntary)

Physician Name: _____ Physician Phone: _____

Employer:

Insurance Policy (Company and Number):

I am my own guardian. Yes No

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.*

Does the athlete have (check any that apply):

List any sports the athlete wishes to play:

Autism Down syndrome Fragile X Syndrome
 Cerebral Palsy Fetal Alcohol Syndrome
 Other syndrome, please specify:

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

Is the athlete allergic to any of the following (please list):

Latex No Known Allergies

Does the athlete use (check any that apply):

Medications:

Insect Bites or Stings:

Food:

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:

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

List all past surgeries:

Does the athlete currently have any chronic or acute infection?

No Yes *If yes, please describe:*

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

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

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
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

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

Epilepsy or any type of seizure disorder No Yes
If yes, list seizure type:

If yes, had 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 (diagnosed) No Yes

Anxiety (diagnosed) No Yes

Describe any additional mental health concerns:

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

Guardian Signature (Only needed if not own guardian)

Date

Relationship to Athlete

Athlete Medical Form-Physical Examination

(to be completed by a Medical Professional *only*)



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 <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 20/40 or better		
in	lbs	Body Fat %	F					Left Vision <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 20/40 or better		
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
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	Splénomegaly		<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	<input type="checkbox"/> NA	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	<input type="checkbox"/> NA	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 below			
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 below			
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular			Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below			
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear			Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below			
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 below			
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 below			
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 below			
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe			Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below			
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe			Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> 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:

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

Licesnsed Medical Examiner's Signature	Date of Exam	Name:	
		Email:	
		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

ATHLETE RELEASE FORM

Special Olympics



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.** If I am unable, or my guardian is unavailable, to make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I check one of these boxes:
 - I have a religious or other objection to receiving medical treatment.
 - 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 athletes (identifying information removed if shared publically); and
 - Protect health and safety, respond to government requests, and report information required by law.

I can ask to see and change my information.

I understand Special Olympics is a global organization with headquarters in the United States of America. I consent to Special Olympics processing my information in countries with different privacy and data security laws, including the United States of America.

ATHLETE NAME: _____

ATHLETE SIGNATURE (required for athlete over 18 years old with capacity to sign legal documents)

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 for athlete under 18 years old or lacking capacity to sign legal documents)

I am a parent or guardian of the Athlete. I have read and understand this form and have explained the contents to the Athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Athlete.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____