

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)



Athlete First & Last Name: _____ Preferred Name: _____

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

COUNTRY: _____ Email: _____

ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

- | | | |
|--|---|---|
| ☐ Autism | ☐ Down Syndrome | ☐ Fragile X Syndrome |
| ☐ Cerebral Palsy | ☐ Fetal Alcohol Syndrome | |
| ☐ Other Syndrome, please specify: _____ | | |

ALLERGIES & DIETARY RESTRICTIONS

- ☐ No Known Allergies
- ☐ Latex
- ☐ Medications: _____
- ☐ Insect Bites or Stings: _____
- ☐ Food: _____

ASSISTIVE DEVICES - 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 |

List any special dietary needs: _____

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play: _____

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

☐ No ☐ Yes If yes, please describe: _____

SURGERIES, INFECTIONS, VACCINES

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 Echocardiogram (Echo)? If yes, describe date and results

- ☐ Yes, had abnormal EKG _____
- ☐ Yes, had abnormal Echo _____

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

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

If yes, list seizure type: _____

If yes, had seizure during the past year? ☐ No ☐ Yes

MENTAL HEALTH

Self-injurious behavior during the past year	☐ No ☐ Yes	Depression (diagnosed)	☐ No ☐ Yes
Aggressive behavior during the past year	☐ No ☐ Yes	Anxiety (diagnosed)	☐ No ☐ Yes

Describe any additional mental health concerns: _____

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: _____

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(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)



Athlete's First and Last Name: _____

HAS THE ATHLETE 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	If female athlete, list date of last menstrual period: _____			

Describe any past broken bones or dislocated joints

(if yes is checked for either of those fields above):

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

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 LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

Name of Person Completing this Form	Relationship to Athlete	Phone	Email
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Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)



Athlete's First and Last Name: _____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI (optional)	Temperature	Pulse	O ₂ Sat	Blood Pressure (in mmHg)		Vision	
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better	☐ No ☐ Yes ☐ N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better	☐ No ☐ Yes ☐ N/A

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

- ☐ Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.
- OR
- ☐ Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

ATHLETE CLEARANCE TO PARTICIPATE (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 needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

- ☐ This athlete is **ABLE** to participate in Special Olympics sports without restrictions.
- ☐ This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe → _____
- ☐ This athlete **MAY NOT participate** in Special Olympics sports at this time & **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 (but not required) 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: _____

Phone: _____

License #: _____

Signature of Licensed Medical Examiner

Exam Date

Athlete Medical Form – MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed)



Athlete's First and Last Name: _____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name: _____

Specialty: _____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

- ☐ 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: _____

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):

☐ Yes ☐ Yes, but with restrictions (*list below*) ☐ 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