

# Athlete Medical Form – HEALTH HISTORY

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

**Special  
Olympics**



Athlete First & Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Athlete Date of Birth (mm/dd/yyyy): \_\_\_\_\_ ☐ Female ☐ Male ☐ Other Gender Identity

STATE PROGRAM: Air Capital Flyers E-mail: \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Autism                                | <input type="checkbox"/> Down Syndrome          | <input type="checkbox"/> Fragile X Syndrome |
| <input type="checkbox"/> Cerebral Palsy                        | <input type="checkbox"/> Fetal Alcohol Syndrome |   |
| <input type="checkbox"/> 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):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Brace                 | <input type="checkbox"/> Colostomy          | <input type="checkbox"/> Communication Device |
| <input type="checkbox"/> C-PAP Machine         | <input type="checkbox"/> Crutches or Walker | <input type="checkbox"/> Dentures             |
| <input type="checkbox"/> Glasses or Contacts   | <input type="checkbox"/> G-Tube or J-Tube   | <input type="checkbox"/> Hearing Aid          |
| <input type="checkbox"/> Implanted Device      | <input type="checkbox"/> Inhaler            | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Removable Prosthetics | <input type="checkbox"/> Splint             | <input type="checkbox"/> 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

Aggressive behavior during the past year

☐ No ☐ Yes

Depression (diagnosed)

☐ 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:

# Athlete Medical Form – HEALTH HISTORY

(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	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Concussions	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular, racing or skipped heart beats	<input type="checkbox"/> No <input type="checkbox"/> Yes	Single Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	Urinary Discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spina Bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Numbness or tingling in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weakness in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head Tilt	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spasticity	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> 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
-------------------------------------	-------------------------	-------	-------

# 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## 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 <sub>2</sub> Sat	Blood Pressure (in mmHg)		Vision
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A

  

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	Splenomegaly <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

## 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:
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam       | <input type="checkbox"/> Acute Infection                  | <input type="checkbox"/> O <sub>2</sub> 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 Splenomegaly                        |
| <input type="checkbox"/> Other, please describe: _____ |   |  |

## Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist      | <input type="checkbox"/> Follow up with a neurologist        | <input type="checkbox"/> Follow up with a primary care physician      |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist        | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist                |
| <input type="checkbox"/> Other/Exam Notes: _____            |  |   |

Signature of Licensed Medical Examiner \_\_\_\_\_ Exam Date \_\_\_\_\_ Name: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ License #: \_\_\_\_\_

# 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      ☐ O<sub>2</sub> 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