Athlete Medical Form

Special Olympics Virginia

DELEGATION/AREA:

☐ MedFest® ☐ Individual Physical

☐ Unified Partner (Medicals Optional) ☐ Healthy Young Athletes

ATHLETE INFORMATION

First Name: Middle Initial:

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:

Does the athlete have (check any that apply):

☐ Autism ☐ Down syndrome Fetal ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ 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	Arthiritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait Easy	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Bleeding Dislocated	☐ No	☐ Yes			
Endocarditis	☐ No	☐ Yes	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 *If* ☐ No ☐ Yes

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:

Custom Item 1:

Custom Item 2:

PLEASE LIST ANY MEDICATION, 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_2Sat	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 Upper	☐ Full	☐ Not full, describe	
Right Leg Edema	☐ No	☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+			Extremity Mobility Lower	☐ Full	☐ Not full, describe	
Left Leg Edema	☐ No	☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+			Extremity Mobility Upper	☐ Full	☐ Not full, describe	
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R		Extremity Strength Lower	☐ Full	☐ Not full, describe	
Cyanosis	☐ No	☐ Yes, describe			Extremity Strength Loss of	☐ Full	☐ Not full, describe	
Clubbing	☐ No	☐ Yes, describe			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)*

Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the phys-ical 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 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
☐ Concerning Neorological Exam
☐ Other, please describe: _____
☐ Acute Infection
☐ Stage II Hypertension or Greater
☐ O_2 Saturation Less Than 90% on Room Air
☐ Hepatomegaly or Splenomegaly

☐ **Additional Licensed Examiner's Notes:**

☐ Follow up with a cardiologist
☐ Follow up with a vision specialist
☐ Follow up with a podiatrist
☐ Follow up with a neurologist
☐ Follow up with a hearing specialist
☐ Follow up with a physical therapist
☐ Follow up with a primary care physician
☐ Follow up with a dentist or dental hygienist
☐ Follow up with a nutritionist

Other _____

Licensed Medical Examiner's Signature Date of Exam _____

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

Athlete's Name

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

Special Olympics

ATHLETE RELEASE FORM
RELEASE TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN OF AN ATHLETE WHO IS UNDER 18 YEARS OF AGE OR IS OVER 18 AND HAS A LEGAL GUARDIAN

I am the parent/guardian of _____, the minor Athlete, on whose behalf I have completed the attached application for participation in Special Olympics. The Athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that to the best of my knowledge and belief, the Athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed medical professional has reviewed the health information set forth in the Athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the Athlete's participation. I understand that if the licensed medical professional has detected symptoms that might result from spinal cord compression, including Atlanto-axial Instability, then the Athlete will only be permitted to participate in Special Olympics sports training and competition if the Athlete has a thorough neurological evaluation from a physician who certifies that the Athlete may participate and I have signed a consent acknowledging that I have been informed of the findings of the physician,

In permitting the Athlete to participate, I am specifically granting my permission, forever, to Special Olympics to use the Athlete's likeness, name, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

I understand the nature and risk of concussion and head injuries, including the risks of continuing to play after concussion or head injury. I acknowledge that Special Olympics has a concussion awareness and safety recognition policy that may require an athlete to seek medical attention from a medical professional in the event of a suspected concussion. Any athlete suspected of sustaining a concussion will not be permitted to return to Special Olympics sports activities until written medical clearance is provided and at least 7 days have passed following from the date of suspected injury. I further acknowledge that additional information regarding concussions may be found on the Centers for Disease Control Heads Up website at http://www.cdc.gov/headsup/youthsports/index.html .

By signing below, I also permit the Athlete to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; podiatry; medicine; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand that notwithstanding my consent, there is no obligation for the Athlete to participate in the Healthy Athletes Program and that I may decide that the Athlete will not participate. I understand that provision of these health services is not intended as a substitute for regular care. I also understand that the Athlete should seek his/her own medical advice and assistance irrespective of the provision of these services and that Special Olympics, through providing these services, is not responsible for the Athlete's health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If a medical emergency should arise during the Athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the Athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the Athlete is provided with any emergency medical treatment, including hospitalization, that Special Olympics deems advisable in order to protect the Athlete's health and well-being. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE *RELIGIOUS OBJECTIONS FORM*.)**

I am the parent and/or guardian of the Athlete named in this application. I have read and fully understand the provisions of the above release, and have explained the contents to the Athlete. Through my signature on this release form, I agree to the above provisions on my own behalf and on the behalf of the Athlete named above.

I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

_____

Signature of Parent/Guardian Date

Special Olympics

ATHLETE RELEASE FORM

TO BE COMPLETED BY AN ATHLETE WHO SIGNS ON HIS OR HER OWN BEHALF

I, _____ am at least 18 years old and I have completed an application for participation in Special Olympics.

1. a) I state that I am physically and mentally able to participate in Special Olympics activities.

   b) I understand that if a doctor has found problems with my neck (Atlanto-Axial Instability) I will only be allowed to participate in Special Olympics sports if:

   - I have another examination and the doctor who checks me for my neck problems says I am able to participate and I sign a form to say I understand what the doctor has told me.

2. Special Olympics has my permission to use my photograph, video, name and voice or words to promote Special Olympics.
3. I agree to participation in Healthy Athletes. If I change my mind, I do not have to go to Healthy Athletes.
4. I know that Special Olympics activities may mean that I sometimes have to stay overnight in a hotel, hostel or someone else's home. If I have any questions about this I will ask the Special Olympics Program staff or volunteers.
5. If I need emergency medical care while I am participating in Special Olympics, I give permission to Special Olympics to do whatever may be necessary to protect my health and well-being, which may include taking me to a hospital. (IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE *RELIGIOUS OBJECTIONS FORM*.)
6. I understand the nature and risk of concussion and head injuries, including the risks of continuing to play after concussion or head injury. I acknowledge that Special Olympics has a concussion awareness and safety recognition policy that may require that I seek medical attention from a medical professional in the event of a suspected concussion. If I am suspected of sustaining a concussion I will not be permitted to return to Special Olympics sports activities until written medical clearance is provided and at least 7 days have passed following from the date of suspected injury. I further acknowledge that additional information regarding concussions may be found on the Centers for Disease Control Heads Up website at http://www.cdc.gov/headsup/youthsports/index.html .

I understand and have read this release and by signing below I say that I agree to this release.

Signature of Athlete: _____ Date: _____