

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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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	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Numbness or tingling in legs, arms, hands or feet	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Weakness in legs, arms, hands or feet	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Head Tilt	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Spasticity	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Paralysis	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	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			Bowel Sounds	Yes	No				
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	NA		Kidney Tenderness	No	Right	Left			
Left Tympanic Membrane	Clear	Perforation	Infection	NA		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 below				
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater			Spasticity	No	Yes, describe below				
Heart Rhythm	Regular	Irregular				Tremor	No	Yes, describe below				
Lungs	Clear	Not clear				Neck & Back Mobility	Full	Not full, describe below				
Right Leg Edema	No	1+ 2+ 3+ 4+				Upper Extremity Mobility	Full	Not full, describe below				
Left Leg Edema	No	1+ 2+ 3+ 4+				Lower Extremity Mobility	Full	Not full, describe below				
Radial Pulse Symmetry	Yes	R>L	L>R			Upper Extremity Strength	Full	Not full, describe below				
Cyanosis	No	Yes, describe				Lower Extremity Strength	Full	Not full, describe below				
Clubbing	No	Yes, describe				Loss of Sensitivity	No	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:

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:

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:

Signature of Licensed Medical Examiner	Exam Date	Name:	
		E-mail:	
		Phone:	License #: