# Athlete Medical Form

This application expires three (3) years from the date of the physical exam.

## REGION:
- North America

## DELEGATION/TIM:
- MedFest®
- Individual Physical
- Unified Partner (Medicals Optional)

## ATHLETE INFORMATION

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Birth (mm/dd/yyyy):</th>
<th>Female: ☐</th>
<th>Male: ☐</th>
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<table>
<thead>
<tr>
<th>Address:</th>
<th>City</th>
<th>Zip</th>
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<tr>
<th>Phone:</th>
<th>Cell:</th>
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<tr>
<th>E-mail:</th>
<th>Eye color:</th>
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<tr>
<th>Athlete’s Primary Care Physician:</th>
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| I am my own guardian. | ☐ Yes | ☐ No |

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

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

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

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

### List all past surgeries:


### List all ongoing or past medical conditions:


### List any special dietary needs:


### List any sports the athlete wishes to play:


### 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 the athlete ever had an abnormal Echocardiogram (Echo)?

- ☐ No
- ☐ Yes

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

- ☐ No
- ☐ Yes

### Has the athlete had a Tetanus vaccine within the past 7 years?

- ☐ No
- ☐ Yes

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### Athlete Name: __________________________

#### PLEASE INDICATE IF THE ATHLETE HAS EVER HAD ANY OF THE FOLLOWING CONDITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Loss of Consciousness</td>
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<tr>
<td>Dizziness during or after exercise</td>
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<td>Headache during or after exercise</td>
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<tr>
<td>Chest pain during or after exercise</td>
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<tr>
<td>Shortness of breath during or after exercise</td>
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<tr>
<td>Irregular, racing or skipped heart beats</td>
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<tr>
<td>Congenital Heart Defect</td>
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<tr>
<td>Heart Attack</td>
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<tr>
<td>Cardiomyopathy</td>
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<td>Heart Valve Disease</td>
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<td>Heart Murmur</td>
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<td>Endocarditis</td>
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<tr>
<td>Any difficulty controlling bowels or bladder</td>
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<td>Numbness or tingling in legs, arms, hands, or feet</td>
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<td>Weakness in legs, arms, hands, or feet</td>
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<td>Burner, stinger, pinched nerve, or pain in neck, back, shoulders, arms, hands, buttocks, legs or feet</td>
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<td>Head Tilt</td>
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<tr>
<td>Spasticity</td>
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<tr>
<td>Paralysis</td>
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#### Additional Questions:

**Ethnic Background:** This solely to help us comply with government record keeping, reporting, and legal requirements:
- White
- Latino/Hispanic
- Black or African
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander

### PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

<table>
<thead>
<tr>
<th>Medication, Vitamin or Supplement</th>
<th>Dosage</th>
<th>Times per Day</th>
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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:** __________________________

**PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes inhalers, birth control or hormone therapy)**

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**Legal Guardian Signature:** __________________________

**Date:** __________________________

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Athlete Name:

**MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Temperature</th>
<th>Pulse</th>
<th>O2Sat</th>
<th>Blood Pressure</th>
<th>Vision</th>
</tr>
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</table>

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

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. (Use Additional Licensed 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  ☐ 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:

☐ 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:

Name:
E-mail:
Phone:
License:

**Licensed Medical Examiner’s Signature**

**Date of Exam**

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FURTHER MEDICAL EVALUATION FORM  (Only to be used if the athlete has previously not been cleared for sports participation above)

<table>
<thead>
<tr>
<th>Examiner’s Name:</th>
<th>Examiner’s Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty:</td>
<td>Specialty:</td>
</tr>
</tbody>
</table>

I have examined this athlete for the following medical concern(s):

Please describe

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In my professional opinion, this athlete:

☐ Yes  ☐ No  May participate in Special Olympics sports (see below for restrictions or limitations)

☐ Additional Examiner Notes:

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E-mail:  E-mail:

Phone:   Phone:

License: License:

---

Examiner’s Signature  Date  Examiner’s Signature  Date

---

Examiner’s Name:  Examiner’s Name:  

Specialty:  Specialty:  

I have examined this athlete for the following medical concern(s):

Please describe

---

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:  E-mail:

Phone:   Phone:

License: License:

---

Examiner’s Signature  Date  Examiner’s Signature  Date
I, the Parent/Guardian or Adult Athlete submits this Official Special Olympics Release Form for participation in Special Olympics.

Section 1
I represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical examiner (MD/DO/NP/PA-C) has reviewed the health information contained in the application for participation and has certified, based on a medical examination, that there is no medical evidence which would preclude the athlete from participating in Special Olympics.

Section 2
I understand that if the athlete has Down syndrome, the athlete cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine unless the athlete and medical examiner have completed the official “Down syndrome Addendum Form”, available from the Special Olympics State Office. I am aware that the x-ray exam is required before any athlete with Down syndrome may participate in equestrian, gymnastics, judo, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and soccer.

Section 3
Special Olympics has my permission, both during and any time after, to use the athlete’s likeness, name, voice or words in either television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

Section 4
If during the athlete’s participation in Special Olympics activities, the athlete should need emergency medical treatment, and I (the parent/guardian or adult athlete) am not able to give consent or make arrangements for that treatment, I authorize Special Olympics to take whatever measures necessary to protect the athlete’s health and well-being, including if necessary, hospitalization.

Section 5
I understand by signing below, that I consent to participate in the Special Olympics Healthy Athletes Program that provides individuals screening assessments of health status and health care needs in the areas of vision, oral health, hearing, physical therapy, and a variety of health promotion areas. I understand there is no obligation for the athlete to participate in the Healthy Athletes Program and that the athlete may decide not to participate. Provisions of these health services are not intended as a substitute for regular health care. I also understand that I should seek independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not responsible for the health of the athlete. I understand that information gathered as part of the screening process may be used anonymously to assess and communicate overall health and needs of athletes and to develop programs to address those needs.

Section 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 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.

To be completed by Adult Athlete (own Guardian)

I, the adult athlete, have read this form and fully understand the provisions of the release that I am signing. I acknowledge that I have read and agree to the Athlete Code of Conduct and the Code of Conduct Compliance Policy. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature __________________________
Print Name __________________________
Date: _____/_____/_____

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Signature __________________________
Print Name __________________________
Date: _____/_____/_____

To be completed by Parent/Guardian

I, the Parent/Guardian of this athlete, hereby give my permission for this athlete to participate in Special Olympics games, training, recreation programs, physical activity programs and Healthy Athletes program. I acknowledge I have read and agree to the Athlete Code of Conduct and the Code of Conduct Compliance Policy. By signing, I am saying that I agree to the provisions of this release.

Signature __________________________
Print Name __________________________
Date: _____/_____/_____

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