



Athlete Medical Form

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

AREA:

MedFest®

Individual Physical

DELEGATION(TEAM):

Unified Partner
(Medicals Optional)

Healthy Young Athletes

ATHLETE INFORMATION

PARENT

GUARDIAN INFORMATION

First Name: Middle Name:

Name:

Last Name:

Phone: Cell:

Date Birth (dd/mm/yyyy): Female: Male:

E-mail:

Address:

Athlete's Primary Care Physician:

Phone: Cell:

Phone:

E-mail: Eye color:

Primary Care Physician Address:

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:

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

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 *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG)?

No Yes *If yes, please describe:*

Has a doctor ever limited the athlete's participation in sports? No Yes

If yes, please describe:

Has the athlete ever had an abnormal Echocardiogram (Echo)? No Yes

If yes, please describe:

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

Athlete Name:

PLEASE INDICATE IF THE ATHLETE HAS EVER HAD 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		
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> 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 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

Additional Questions:

Ethnic Background-This is solely to help us comply with government record keeping, reporting, and legal requirements:

- White
- Latino/Hispanic
- Black or African American
- American Indian or Alaska Native
- Asian

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:

Additional Questions:

Health Insurance information:

Healthcare provider _____

Policy Number _____

Emergency Contact information _____

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes 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 Name:

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

Height	Weight	Temperature	Pulse	O ₂ Sat	Blood Pressure	Vision
<input type="text"/> cm	<input type="text"/> kg	<input type="text"/> C	<input type="text"/>	<input type="text"/>	BP Right <input type="text"/> BP Left <input type="text"/>	Right Vision <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 20/40 or better
<input type="text"/> in	<input type="text"/> lbs	<input type="text"/> F	<input type="text"/>	<input type="text"/>		Left Vision <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 20/40 or better
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds <input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds	<input type="checkbox"/> No <input type="checkbox"/> Yes		
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 checked="" type="checkbox"/> LLQ		
Right Tympanic Membrane	<input type="checkbox"/> Clear <input type="checkbox"/> Perforation	<input type="checkbox"/> Infection	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	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		
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		
Heart Rhythm	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular		Tremor	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe		
Lungs	<input type="checkbox"/> Clear <input type="checkbox"/> Not clear		Neck & Back Mobility	<input type="checkbox"/> Full <input type="checkbox"/> Not full, describe		
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		
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		
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		
Cyanosis	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full <input type="checkbox"/> Not full, describe		
Clubbing	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe		Loss of Sensitivity	<input type="checkbox"/> No <input type="checkbox"/> 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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam | <input type="checkbox"/> Acute Infection | <input type="checkbox"/> O ₂ 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 |

Other, please describe:

Additional Licensed Examiner's Notes:

- | | | |
|---|--|---|
| <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 |

Other:

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

Athlete 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:

Examiner's Name:
Specialty:

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

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:

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:

E-mail:
Phone:
License:

Examiner's Signature

Date

Examiner's Signature

Date

Examiner's Name:
Specialty:

Examiner's Name:
Specialty:

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

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:

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:

E-mail:
Phone:
License:

Examiner's Signature

Date

Examiner's Signature

Date



OFFICIAL SPECIAL OLYMPICS CONSENT FORM

Athlete Name: First _____ Last _____

D.O.B.: ____/____/____

**RELEASE TO BE COMPLETED BY PARENT/GUARDIAN OR ADULT ATHLETE (OWN GUARDIAN)
THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED, AND DATED TO BE CONSIDERED VALID FOR THREE (3) YEARS**

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 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 since the date of the 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)

OR

To be completed by Parent/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: ____/____/____

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: ____/____/____