

# Athlete Medical Form – HEALTH HISTORY

Pages 1-3 to be completed by the athlete or parent/guardian/caregiver.

SEND TO: SPECIAL OLYMPICS DELAWARE, 619 S. COLLEGE AVE., NEWARK, DE 19716

**Special  
Olympics**  
Delaware



AREA:

NAME OF SCHOOL:

## ATHLETE INFORMATION

First Name:  Middle Name:

Last Name:

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

Address (Street):

Address (City, State, Zip):

Phone:  Cell:

E-mail:

Eye color:  Ethnicity:  (optional)

Athlete Employer, if any:

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):

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

List any special dietary needs:

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, select below and describe

Yes, had abnormal EKG  Yes, had abnormal Echo

PARENT  GUARDIAN INFORMATION (if not own guardian)

Name:

Phone:  Cell:

E-mail:

Emergency Contact Name:  Same as Above:

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the athlete have a primary care physician?  Yes  No If yes, list.

Physician Name:  Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?

No  Yes If yes, contact your local Program to get the Emergency Care Refusal Form.

List any sports the athlete wishes to play:

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

No  Yes If yes, please describe:

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

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

## 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's 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						

<b>Difficulty controlling bowels or bladder</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, is this new or worse in the past 3 years?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Numbness or tingling in legs, arms, hands or feet</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, is this new or worse in the past 3 years?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Weakness in legs, arms, hands or feet</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, is this new or worse in the past 3 years?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, is this new or worse in the past 3 years?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Head Tilt</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, is this new or worse in the past 3 years?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Spasticity</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, is this new or worse in the past 3 years?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Paralysis</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>If yes, is this new or worse in the past 3 years?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**Describe any past broken bones or dislocated joints** (if yes is checked for either of those fields above):

**Epilepsy or any type of seizure disorder**  No  Yes

*If yes, list seizure type:*

*If yes, had 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 (diagnosed)**  No  Yes

**Anxiety (diagnosed)**  No  Yes

**Describe any additional mental health concerns:**

**List any other ongoing or past medical conditions:**

**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 athlete, list date of last menstrual period:**

<b>Name of Person Completing this Form</b>	<b>Relationship to Athlete</b>	<b>Phone</b>	<b>Email</b>



## PARTICIPANT RELEASE FORM

Name: \_\_\_\_\_

I want to take part in Special Olympics and agree to the following:

- 1. Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.
- 2. Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.
- 3. Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
- 4. Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:
  - I have a religious or other objection to receiving medical treatment.
  - I consent to emergency medical care, but I do not consent to blood transfusions.(If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
- 5. Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.
- 6. Personal Information.** I understand my information may be used and shared by Special Olympics to:
  - Make sure I am eligible and can participate safely;
  - Run trainings and events and share results;
  - Put my information in a computer system;
  - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
  - Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publically); and
  - Protect health and safety, respond to government requests, and report information required by law.I can ask to see and revise my information. I can ask to limit how my information is used.
- 7. Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

**PARTICIPANT NAME:** \_\_\_\_\_

**PARTICIPANT SIGNATURE** (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** (required if under 18 years old or has a legal guardian)

I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

# Athlete Medical Form – PHYSICAL EXAM

(to be completed by a Medical Professional only)



Athlete's Name:

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

Height	Weight	BMI (optional)	Temperature	Pulse	O <sub>2</sub> Sat	Blood Pressure	Vision	
<input type="text"/> cm	<input type="text"/> kg	<input type="text"/> BMI	<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"/> Body Fat %	<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"/> 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		

### ATLANTO-AXIAL INSTABILITY (AAI)

- Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings 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 **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 needs further medical evaluation please use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance..

This athlete is **ABLE** to participate in Special Olympics sports without restrictions/limitations

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions/limitations →

This athlete **MAY NOT participate** in Special Olympics sports at this time and **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: <input type="text"/>		

### Additional Licensed Examiner's Notes and Recommended 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                |

Other/Exam Notes:

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

# Athlete Medical Form – MEDICAL REFERRAL FORM

(to be completed by a Medical Professional only if referral is needed)



Athlete's Name:

**This page only needs to be completed and signed if the physician on page four does not clear the athlete and indicates follow-up is required. Athlete should bring the previously completed pages to the appointment with the specialist.**

Examiner's Name:

Specialty:

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

In my professional opinion, this athlete **MAY** participate in Special Olympics sports (indicate restrictions or limitations below):

Yes, without restrictions       Yes, but with restrictions (*list below*)       No

Additional Examiner Notes/Restrictions:

Examiner E-mail:

Examiner Phone:

License:

<b>Examiner's Signature</b>	<b>Date</b>

### 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