

# Athlete Medical Form



The form consists of two sections.

Section 1: *Mandatory* For all Athletes participating in Special Olympics activities, including one day sporting events, practices, and competitions to complete. For overnight Special Olympics Events or Games, Section 2: *must* be completed by a licensed medical professional authorized under the laws of the Accredited Program's jurisdiction.

**Complete form using block capital letters.**

## Section 1: All Athletes Complete

To be completed by the athlete or parent/guardian/caregiver.

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Preferred name: \_\_\_\_\_

Date of birth (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Female Male Other

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Home address: \_\_\_\_\_ Country: \_\_\_\_\_

### Emergency Contact

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

### Associated Conditions - Mandatory

Associated Conditions	Autism	Cerebral Palsy	Down Syndrome	Fetal Alcohol Syndrome
<b>Check all that apply:</b>	Marfan Syndrome	Spina Bifida	Epilepsy	Fragile X Syndrome
	Other	Unknown		
Please specify other known intellectual disability diagnoses:				

### Assistive Devices and Accommodations - Do you use any of the following? Check all that apply:

Mobility	Walker Prosthetics	Braces or crutches None	Wheelchair	Removable orthotics
Lifestyle Aids	CPAP Glasses, contact lenses, or protective eyewear	Colostomy	Inhaler None	Dentures
Communications	Hearing aid	Communication devices	Sign language	None
Medical Devices	Implantable cardioverter defibrillator (ICD) VP shunt	Spinal cord stimulator	Implantable device for seizure management Pacemaker	None

Do you have a specific dietary requirement?	Yes	No	If yes, please specify:
Do you use other assistive devices?	Yes	No	If yes, please specify:

**General Health Questions**

Do you have a heart condition?	Yes	No
Do you have asthma?	Yes	No
Do you have diabetes that requires you to take insulin?	Yes	No
Do you have a vision impairment?	Yes	No
Do you have a hearing impairment?	Yes	No
Do you have a bleeding disorder?	Yes	No
Has a doctor ever limited your participation in sports?	Yes	No
Do you have epilepsy or any type of seizure disorder?	Yes	No
Do you have sickle cell disease?	Yes	No

Have you ever had a concussion?	Yes	No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	Yes	No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	Yes	No	If yes, please specify if it is to any of the following: Insect stings                      Medication/drugs Food                                      Latex Other (please specify): _____

**Medication and Treatment - Please list:**

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

Yes                      No

**If yes, please list:**

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Today's date (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Name/signature of person completing the form: \_\_\_\_\_

Is this form being completed by someone other than the athlete?                      Yes                      No

If form is being completed by someone other than the athlete, please select the relationship to athlete.

Relationship to athlete:      Parent/guardian      Caregiver      Family member      Healthcare provider      Coach      Other

**Section 2: For completion for Games and/or Overnight Events**

**Medical Physical Examination - To be completed by examiner only.**

**To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.**

Athlete first and last name: \_\_\_\_\_ Date of birth (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Height (in/cm)	Weight (lb/kg)	Waist Circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood Pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Does the athlete present with any of the following?							
High Blood Pressure	Yes	No		Coeliac Disease	Yes	No	Unknown
Kidney Disease	Yes	No	Unknown	Osteoporosis	Yes	No	Unknown
Anemia	Yes	No	Unknown	Non-verbal	Yes	No	

Has any family member or relative died of heart problems or of sudden death before age 50?	Yes	No
Was the athlete born without or missing a kidney, an eye, a testicle, or any other organ?	Yes	No

Does the athlete have any past surgeries?	Yes	No	Unknown	If yes, please list all:
Did the athlete ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	Yes	No	Unknown	If yes, please specify:
Did the athlete ever have any broken bones or dislocated joints?	Yes	No	Unknown	If yes, please specify:
Does the athlete have liver disease?	Yes	No	Unknown	If yes, please specify:
Does the athlete have lung disease?	Yes	No	Unknown	If yes, please specify:
Does the athlete have heart disease?	Yes	No	Unknown	If yes, please specify:

<b>Medical</b>			
Eyes, ears, nose, and throat: include pupils, hearing	Normal	Abnormal	Findings:
Heart: Include murmurs (auscultation standing, auscultation supine, and ± valsava maneuver)	Normal	Abnormal	Findings:
Lungs	Normal	Abnormal	Findings:
Abdomen	Normal	Abnormal	Findings:
Skin: HSV, MRSA, or tinea corporis	Normal	Abnormal	Findings:
Neurological	Normal	Abnormal	Findings:

<b>Musculoskeletal</b>			
Neck	Normal	Abnormal	Findings:
Back	Normal	Abnormal	Findings:
Shoulder and arm	Normal	Abnormal	Findings:
Elbow and forearm	Normal	Abnormal	Findings:
Wrist, hand, and fingers	Normal	Abnormal	Findings:
Hip and thigh	Normal	Abnormal	Findings:
Knee	Normal	Abnormal	Findings:
Lower leg and ankle	Normal	Abnormal	Findings:
Foot and toes	Normal	Abnormal	Findings:

**Medical Physical Examination - To be completed by examiner only.**

**MEDICAL ELIGIBILITY FOR SPORT (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 provide information regarding the licensed healthcare provider below. That provider should complete a referral below and second physician for referral should complete page 4.*

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: \_\_\_\_\_

Not medically eligible pending further evaluation of: \_\_\_\_\_

Not medically eligible to participate in the following sports: \_\_\_\_\_

Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_

Date (dd/mm/yyyy): \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_

NPI or License number: \_\_\_\_\_

License type (MD, DO, NP, or PA): \_\_\_\_\_