Athlete Medical Form

Special Olympics New York

To be completed by Special Olympics

REGION:

DELEGATION/TEAM:

☐ MedFest®
☐ Unified Partner (Medicals Optional)
☐ Individual Physical
☐ Healthy Young Athletes

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

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

Address:

Phone: Cell:

E-mail: Eye color:

I am my own guardian. ☐ Yes ☐ No

☐ PARENT ☐ GUARDIAN INFORMATION

Name:

Phone: Cell:

E-mail:

Athlete's Primary Care Physician:

Phone:

Primary Care Physician Address:

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 *If yes, please complete the religious objections form.*

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's Name:

PLEASE INDICATE IF THE ATHLETE HAS EVER HAD 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 heat 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			
Endocarditis	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ 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

Custom Item 1: ☐ No ☐ Yes

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:

Custom Item 2: ☐ No ☐ Yes

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:**

Athelete Signature Date Legal Guardian Signature Date

Athlete's Name: _____

Form C-1B

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

Height	Weight	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
____ cm	____ kg	____ C			BP Right ____	BP Left ____	**Right Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better
____ in	____ lbs	____ F					**Left Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better

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	☐ LUQ ☐ 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 ☐ O_2 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: _____

Licensed Medical Examiner's Signature Date of Exam Phone: _____ License: _____

Athlete's 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:

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:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

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:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

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:

Phone:

License:

Examiner's Signature Date

Examiner's Name:

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:

Phone:

License:

Examiner's Signature Date