

# Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by the athlete or parent/guardian/caregiver)

Special  
Olympics  
Maryland



REGION/AREA:

New Athlete

Re-Registering (Returning) Athlete

DELEGATION/TEAM:

## 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:

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**Athlete's Name:**

**HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED 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 heart 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	Dislocated Joints	No	Yes
Endocarditis	No	Yes						

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

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

  
  

<b>Epilepsy or any type of seizure disorder</b>	No	Yes
<i>If yes, list seizure type:</i>		
<i>If yes, had seizure during the past year?</i>	No	Yes
<b>Self-injurious behavior during the past year</b>	No	Yes
<b>Aggressive behavior during the past year</b>	No	Yes
<b>Depression (diagnosed)</b>	No	Yes
<b>Anxiety (diagnosed)</b>	No	Yes
<b>Describe any additional mental health concerns:</b>		

**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>
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# 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				
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better	No	Yes	N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better	No	Yes	N/A
Right Hearing (Finger Rub)	Responds	No Response	Can't Evaluate	Bowel Sounds	Yes	No					
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	NA	Kidney Tenderness	No	Right	Left			
Left Tympanic Membrane	Clear	Perforation	Infection	NA	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 below					
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater	Spasticity	No	Yes, describe below					
Heart Rhythm	Regular	Irregular		Tremor	No	Yes, describe below					
Lungs	Clear	Not clear		Neck & Back Mobility	Full	Not full, describe below					
Right Leg Edema	No	1+	2+	3+	4+	Upper Extremity Mobility	Full	Not full, describe below			
Left Leg Edema	No	1+	2+	3+	4+	Lower Extremity Mobility	Full	Not full, describe below			
Radial Pulse Symmetry	Yes	R>L	L>R	Upper Extremity Strength	Full	Not full, describe below					
Cyanosis	No	Yes, describe		Lower Extremity Strength	Full	Not full, describe below					
Clubbing	No	Yes, describe		Loss of Sensitivity	No	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:

Concerning Cardiac Exam	Acute Infection	O <sub>2</sub> 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 and Recommended Follow-up:

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/Exam Notes:		

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

# 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 three 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

**ATHLETE PARTICIPATION WAIVER**



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

1. **Able to Participate.** I am eligible and able to take part in Special Olympics activities. 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 without compensation to me, my family or representatives.
3. **Overnight Stay.** For some events, I may be required to stay overnight. I understand the health and safety of all Special Olympics Maryland participants is of paramount importance to Special Olympics Maryland. Athletes will be matched for housing based on size, level of maturity, ability and age. Each **member** of the delegation shall be assigned his/her own bed. Athletes and volunteers may not share a room with an athlete or volunteer of the opposite sex \*. The chaperone/athlete ratio of at least one properly registered chaperone to every four athletes must be maintained during overnight events. All chaperones must be screened in accordance with the Special Olympics Volunteer Screening Policy. \*See complete Special Olympics Maryland Housing Policy for allowed exceptions. The complete Special Olympics Maryland Housing Policy can be found at [www.somd.org](http://www.somd.org) 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 publicly); 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. Go here for more Concussion information: <https://www.cdc.gov/headsup/>

**PARTICIPANT NAME:** \_\_\_\_\_ **AREA/COUNTY PARTICIPATING WITH:** \_\_\_\_\_

**PARTICIPANT SIGNATURE** (required if 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: \_\_\_\_\_