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Athlete Medical Form – HEALTH HISTORY

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

Special Olympics Maryland

REGION/AREA: Maryland

DELEGATION/TEAM: Montgomery County

☐ New Athlete
☐ Re-Registering (Returning) Athlete

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 Medical Form – HEALTH HISTORY

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

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						

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

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:**

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**

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Athlete Medical Form – **PHYSICAL EXAM**

(to be completed by a Medical Professional only)

Special Olympics Maryland

Athlete's Name:

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

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
cm / in	kg / lbs	BMI / Body Fat %	C / F			BP Right:	BP Left:	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A 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_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 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:

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

This page MUST BE RETURNED (If Referred)

Athlete Medical Form – MEDICAL REFERRAL FORM

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

Special Olympics Maryland

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:

Examiner's Signature	**Date**

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