

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)



Medical Form Valid for 3 years from date of medical professional's signature

Region _____ Primary Agency Name _____ Secondary Agency Name _____

Name of person completing form: _____ Relationship to Athlete _____

Phone _____ - _____ - _____ Email Address _____ Date Completed _____

If individual is a new athlete, has turned 18 since their last Medical Form submission or has a change in their guardianship status then a Special Olympics Illinois Consent Form must be submitted with the Medical Form.

ATHLETE INFORMATION

Athlete Last Name: _____ Athlete First Name: _____

Preferred Name: _____ Athlete Date of Birth (mm/dd/yyyy): _____

Athlete Gender Identity: Female Male Other

Athlete Ethnicity/Race:

Asian

American Indian/Alaskan Native

Black/African American

Hispanic/Latino

Native Hawaiian/Other Pacific Islander

W White

Two or More Races

Other

Prefer Not to Answer

If a new athlete, has athlete ever been convicted or charged with a criminal offense other than minor traffic violations? No Yes

If a currently registered athlete, in the past 3 years has athlete been convicted or charged with a criminal offense other than minor traffic violations? No Yes *If the answer to either question is Yes, Special Olympics Illinois may require additional information from the athlete or responsible parent/guardian.*

Athlete Mailing Address: Street _____ City: _____ State: _____ Zip: _____

Athlete Email Address: _____ Athlete Phone Number: _____ - _____ - _____

Athlete Employer (if applicable): _____

Name of Athlete's Primary Physician / Health Provider: _____

PARENT / GUARDIAN INFORMATION

Athlete is or is not their own guardian (Please mark appropriate box)

The following information is for the Parent or Guardian of the athlete listed above.

Last Name: _____ First Name: _____

Mailing Address (if different than athlete's):

Street: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Contact Number: _____ - _____ - _____

EMERGENCY CONTACT INFORMATION (Must list at least one emergency contact)

Emergency Contact Person #1: Name _____ Phone: _____ - _____ - _____

Emergency Contact Person #2: Name _____ Phone: _____ - _____ - _____

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Athlete's First and Last Name: _____

DIAGNOSED SYNDROMES (check all that apply)

Autism Down Syndrome Fragile X Syndrome Cerebral Palsy Fetal Alcohol Syndrome Other: _____

HEART HEALTH & HISTORY (check all that apply)

Congenital Heart Defect	No	Yes	Treated in past 12 months	Heart Murmur	No	Yes	Treated in past 12 months
Heart Attack	No	Yes	Treated in past 12 months	Heart Illness	No	Yes	Treated in past 12 months
High Blood Pressure	No	Yes	Treated in past 12 months	Chest pain during or after exercise	No	Yes	Treated in past 12 months
Cardiomyopathy	No	Yes	Treated in past 12 months	Ever had abnormal EKG	No	Yes	Treated in past 12 months
Pacemaker	No	Yes	Treated in past 12 months	Ever had abnormal Echo	No	Yes	Treated in past 12 months
Heart Valve Disease	No	Yes	Treated in past 12 months	Other: _____	No	Yes	Treated in past 12 months

HEAD INJURY HISTORY (check all that apply)

Concussion(s) No Yes Treated in past 12 months
Traumatic Brain Injury (TBI) No Yes Treated in past 12 months Other: _____ No Yes Treated in past 12 months

VISION AND/OR HEARING ISSUES (check all that apply)

Legally Blind Deaf Glasses or Contacts
Vision Impaired Hearing Impaired Hearing Aids

ALLERGIES & DIETARY RESTRICTIONS (check all that apply & explain when indicated)

Latex Insect Bites or Stings: _____
Food: _____ Medications: _____ Other: _____

PULMONARY HEALTH & HISTORY (check all that apply)

Asthma	No	Yes	Treated in past 12 months	Sleep Apnea (C-PAP Machine)	No	Yes	Treated in past 12 months
COPD	No	Yes	Treated in past 12 months	Other: _____	No	Yes	Treated in past 12 months
Uses an Inhaler	No	Yes	Treated in past 12 months				

MENTAL HEALTH (check all that apply)

Self-injurious behavior during the past year No Yes Anxiety (diagnosed) No Yes Depression (diagnosed) No Yes
Aggressive behavior during the past year No Yes Describe any additional mental health concerns: _____

OTHER MEDICAL CONDITIONS (check all that apply)

Stroke/TIA	No	Yes	Treated in past 12 months	Arthritis	No	Yes	Treated in past 12 months
Diabetes	No	Yes	Treated in past 12 months	Dislocated Joints	No	Yes	Treated in past 12 months
Heat Exhaustion	No	Yes	Treated in past 12 months	Syncope	No	Yes	Treated in past 12 months
Heat Stroke	No	Yes	Treated in past 12 months	Hepatitis	No	Yes	Treated in past 12 months
Colostomy	No	Yes	Treated in past 12 months	Sickle Cell Trait/Disease	No	Yes	Treated in past 12 months
G-Tube or J-Tube	No	Yes	Treated in past 12 months	Seizure Disorder	No	Yes	Treated in past 12 months
Epilepsy	No	Yes	Treated in past 12 months	Other: _____	No	Yes	Treated in past 12 months

Has athlete had a Tetanus vaccine in past 7 years? No Yes Date of Shot _____

Is athlete pregnant? No Yes Expected Due Date _____ Month _____ Year

NEUROLOGICAL SYMPTOMS FOR SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (check all that apply)

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

LIST ANY MEDICATION, VITAMINS OR DIETARY/HERBAL/NUTRITIONAL SUPPLEMENTS (includes inhalers, birth control, hormone therapy)

Medication/Vitamin/Supplement Name: _____ Dosage: _____ Times Per Day: _____
Medication/Vitamin/Supplement Name: _____ Dosage: _____ Times Per Day: _____
Medication/Vitamin/Supplement Name: _____ Dosage: _____ Times Per Day: _____

Is the athlete able to administer their own medications? No Yes

Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)



Athlete's First and Last Name: _____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI (optional)	Temperature	Pulse	O ₂ Sat	Blood Pressure (in mmHg)		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				

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)

Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.

OR

Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

ATHLETE CLEARANCE TO PARTICIPATE (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 make a referral below and second physician for referral should complete page 4.

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

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe → _____

This athlete **MAY NOT participate** in Special Olympics sports at this time & **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 (but not required) 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:
Signature of Licensed Medical Examiner	Exam Date	Phone - -

Athlete Medical Form – MEDICAL REFERRAL FORM

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



Athlete's First and Last Name: _____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name: _____

Specialty: _____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

Concerning Cardiac Exam Acute Infection O₂ Saturation Less than 90% on Room Air

Concerning Neurological Exam Stage II Hypertension or Greater Hepatomegaly or Splenomegaly

Other, please describe:

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

Yes

Yes, but with restrictions (*list below*)

No

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

Examiner's Signature

Date