Athlete Medical Form

Special Olympics Texas

Area 10	Delegation Code LEW10	Delegation Name Lewisville I.S.D. Special Olympics

❍ Individual Physical ❍ MedFest® ❍ Unified Partner *(medicals optional)* ❍ Healthy Young Athletes

ATHLETE INFORMATION		
Last Name	First Name	
Middle Name	Nickname	
Date of Birth ___ ___ /___ ___ /___ ___ ___ ___ MM/DD/YYYY	Gender ❍ Male ❍ Female	Eye Color
Address	City/State/Zip	
Home Phone ( )	Cell Phone ( )	
Email	I am my own guardian. ❍ Yes ❍ No	
Employer	Employer's Phone	
Employer's Address	City/State/Zip	
Sports the athlete is interested in playing:		

PARENT/GUARDIAN INFORMATION	
Relationship to Athlete	
Last Name	First Name
Home Phone ( )	Cell Phone ( )
Address	City/State/Zip
Email	
Employer	Employer's Phone
Employer's Address	City/State/Zip

ATHLETE MEDICAL INFORMATION	
Primary Care Physician	Physician's Phone ( )
Physician's Address	City/State/Zip

The athlete has *(check all that apply)* ❍ Autism ❍ Down Syndrome ❍ Fragile X Syndrome ❍ Cerebral Palsy ❍ Fetal Alcohol Syndrome ❍ Other syndrome *(please specify)*:

The athlete uses *(check any that apply)*
❍ Dentures ❍ Communication Device ❍ Wheelchair ❍ 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

Athlete's Allergies *(please list)* ❍ No Known Allergies ❍ Latex
❍ Insect Bites or Stings:
❍ Food:
❍ Medications:

Special Dietary Needs

Does the athlete have any religious objections to medical treatment? ❍ No ❍ Yes *If yes, please complete the religious objections form.*

Does the athlete currently have any chronic or acute infection? ❍ No ❍ Yes *If yes, please describe:*

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Athlete Last Name	Athlete First Name

ATHLETE MEDICAL HISTORY

List all past surgeries:

List all ongoing or past medical conditions:

List all medical conditions that run in the athlete's family:

Has any relative died of a heart problem before age 40? ❍ No ❍ Yes

Has any relative died while exercising? ❍ No ❍ Yes

Has a doctor ever limited the athlete's participation in sports? ❍ No ❍ Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG)? ❍ 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

PLEASE INDICATE IF THE ATHLETE HAS EVER HAD ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	❍ No	❍ Yes	High Cholesterol	❍ No	❍ Yes	Asthma	❍ No	❍ Yes
Dizziness during or after exercise	❍ No	❍ Yes	Vision Impairment	❍ No	❍ Yes	Diabetes	❍ No	❍ Yes
Headache during or after exercise	❍ No	❍ Yes	Hearing Impairment	❍ No	❍ Yes	Hepatitis	❍ No	❍ Yes
Chest pain during or after exercise	❍ No	❍ Yes	Enlarged Spleen	❍ No	❍ Yes	Urinary Discomfort	❍ No	❍ Yes
Shortness of breath during or after exercise	❍ No	❍ Yes	Single Kidney	❍ No	❍ Yes	Spina Bifida	❍ No	❍ Yes
Irregular, racing or skipped heat beats	❍ No	❍ Yes	Osteoporosis	❍ No	❍ Yes	Arthritis	❍ No	❍ Yes
Congenital Heart Defect	❍ No	❍ Yes	Osteopenia	❍ No	❍ Yes	Heat Illness	❍ No	❍ Yes
Heart Attack	❍ No	❍ Yes	Sickle Cell Disease	❍ No	❍ Yes	Broken Bones	❍ No	❍ Yes
Cardiomyopathy	❍ No	❍ Yes	Sickle Cell Trait	❍ No	❍ Yes	*Please describe any broken bones or dislocated joints:*		
Heart Valve Disease	❍ No	❍ Yes	Easy Bleeding	❍ No	❍ Yes			
Heart Murmur	❍ No	❍ Yes	Dislocated Joints	❍ No	❍ Yes			
Endocarditis	❍ No	❍ Yes	Stroke/TIA	❍ No	❍ Yes			
High Blood Pressure	❍ No	❍ Yes	Concussions	❍ 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
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:

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Athlete Last Name	Athlete First Name

MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS *(includes inhalers, birth control or hormone therapy)*

Name of Medication	Dosage	Times per Day	Name of Medication	Dosage	Times per Day
Is the athlete able to administer his/her own medications? ❍ No ❍ Yes			If female, date of athlete's last menstrual period:		

PLEASE READ BEFORE SIGNING

It is understood and agreed that: If the examiner is provided free of charge, it is not intended to be a thorough or comprehensive examination. No physician-patient relationship is to arise out of the examination. The doctor, nurse or other person involved in the examination is under no obligation to provide a diagnosis, treatment, advice, consultation or any follow-up care whatsoever under any circumstances. The fact that any person is cleared or authorized to participate in any sport or other activity does not mean and is not to be interpreted as the opinion of the doctor or nurse that the person examined is healthy, in need of no care, or can participate in any sport or other activity without serious medical risks. Any claim against the doctor, nurse or other person involved in the examination will be submitted to binding arbitration pursuant to the rules and procedures of the American Arbitration Association. The person examined and any person who signs on his or her behalf promises to indemnify the doctor or nurse from any and all damages, claims, or losses, including injury or death that allegedly arise out of or are in any way related to the examination.

Participation: I hereby give my permission for the participant named above to participate in any Special Olympics activity or event of any kind. I understand that participation at local or area competition does not guarantee advancement to State or World Games. Athletes must be registered using this release form prior to any athlete training.

Medical: I represent and warrant to you that the athlete is physically and mentally able to participate in Special Olympics Texas.

Disclaimer: On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release the physicians, organizers, officers, directors, agents or employees of Special Olympics Texas from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or the athlete.

Hospitalization: If I am not personally present at the event in which the athlete is to compete so as to be consulted in case of emergency, you are authorized on my behalf and at my account to take such measure and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete.

Media: In permitting the athlete to participate, I am specifically granting permission to you to use the name, likeness, voice, words, and biographical information of the athlete in television, radio, films, newspapers, magazines, web pages and other media, and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of Special Olympics Texas and in appealing for funds to support such activities.

SOTX Housing Policy: For any overnight trip, a gender-specific athlete to chaperone ratio of 4 to 1 is required (see SIG section N for specific breakdown). No athletes or volunteers of opposite genders may room together. The only exceptions are: if the athletes/volunteers are married; or if a family member of the opposite gender is chaperoning. Unified Partners under the age of 17 should be included in the ratio as in need of a chaperone.

ATHLETE OR PARENT/GUARDIAN SIGN AND DATE

Printed Name	*Check One:* ❍ Parent ❍ Guardian ❍ Athlete (if over the age of 18)
Signature	Date

Athlete Physical

TO BE COMPLETED BY MEDICAL EXAMINER ONLY

Special Olympics Texas

Athlete Last Name	Athlete First Name

ATHLETE MEDICAL PHYSICAL INFORMATION

Height _____ cm _____ in	Weight _____ kg _____ lbs	Temp _____ °C _____ °F	Pulse	O_2Sat
Blood Pressure: BP Right		Blood Pressure: 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			
Left Hearing (Finger Rub)	❍ Responds	❍ No Response	❍ Can't Evaluate			
Right Ear Canal	❍ Clear	❍ Cerumen	❍ Foreign Body			
Left Ear Canal	❍ Clear	❍ Cerumen	❍ Foreign Body			
Right Tympanic Membrane	❍ Clear	❍ Perforation	❍ Infection			
Left Tympanic Membrane	❍ Clear	❍ Perforation	❍ Infection			
Oral Hygiene	❍ Good	❍ Fair	❍ Poor			
Thyroid Enlargement	❍ No	❍ Yes				
Lymph Node Enlargement	❍ No	❍ Yes				
Heart Murmur (supine)	❍ No	❍ 1/6 or 2/6	❍ 3/6 or greater			
Heart Murmur (upright)	❍ No	❍ 1/6 or 2/6	❍ 3/6 or greater			
Heart Rhythm	❍ Regular	❍ Irregular				
Lungs	❍ Clear	❍ Not clear				
Right Leg Edema	❍ No	❍ 1+	❍ 2+	❍ 3+	❍ 4+	
Left Leg Edema	❍ No	❍ 1+	❍ 2+	❍ 3+	❍ 4+	
Radial Pulse Symmetry	❍ Yes	❍ R>L	❍ L>R			
Cyanosis	❍ No	❍ Yes, describe				
Clubbing	❍ No	❍ Yes, describe				

Bowel Sounds	❍ No	❍ Yes			
Hepatomegaly	❍ No	❍ Yes			
Splenomegaly	❍ No	❍ Yes			
Abdominal Tenderness	❍ No	❍ RUQ	❍ RLQ	❍ LUQ	❍ LLQ
Kidney Tenderness	❍ No	❍ Right	❍ Left		
Right upper extremity reflex	❍ Normal	❍ Diminished	❍ Hyperreflexia		
Left upper extremity reflex	❍ Normal	❍ Diminished	❍ Hyperreflexia		
Right lower extremity reflex	❍ Normal	❍ Diminished	❍ Hyperreflexia		
Left lower extremity reflex	❍ Normal	❍ Diminished	❍ Hyperreflexia		
Abnormal Gait	❍ No	❍ Yes, describe			
Spasticity	❍ No	❍ Yes, describe			
Tremor	❍ No	❍ Yes, describe			
Neck & Back Mobility	❍ Full	❍ Not full, describe			
Upper Extremity Mobility	❍ Full	❍ Not full, describe			
Lower Extremity Mobility	❍ Full	❍ Not full, describe			
Upper Extremity Strength	❍ Full	❍ Not full, describe			
Lower Extremity Strength	❍ Full	❍ Not full, 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

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 next page: Special Olympics Further Medical Evaluation Form, in order to provide the athlete with medical clearance.*

❍ **YES** - This athlete is able to participate in Special Olympics sports. (Use Additional Licensed Examiner's Notes for any restrictions or limitations).

❍ **NO** - 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
❍ Concerning Neurological Exam
❍ Other, please describe:
❍ Acute Infection
❍ Stage II Hypertension or Greater
❍ O_2 Saturation Less than 90% on Room Air
❍ Hepatomegaly or Splenomegaly

Additional Licensed Examiner Notes:

❍ Follow up with a cardiologist
❍ Follow up with a vision specialist
❍ Follow up with a podiatrist
❍ Other, please describe:
❍ Follow up with a neurologist
❍ Follow up with a hearing specialist
❍ Follow up with a physical therapist
❍ Follow up with a primary care physician
❍ Follow up with a dentist or dental hygienist
❍ Follow up with a nutritionist

MEDICAL EXAMINER SIGN AND DATE

Signature of Licensed Physician, Physician's Assistant licensed by State Board of Physicians Assistant Examiners, or Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.	Date of Exam
Printed Name	Email
Phone ( )	License

Further Medical Evaluation Form

ONLY TO BE USED IF THE ATHLETE HAS PREVIOUSLY NOT BEEN CLEARED FOR SPORTS PARTICIPATION ON THE PREVIOUS PAGE

Special Olympics Texas

Athlete Last Name	Athlete First Name

FURTHER MEDICAL EVALUATION

Examiner's Name	Specialty
I have examined this athlete for the following medical concern(s): *Please describe.*	
❍ **YES** ❍ **NO** In my professional opinion, this athlete may participate in Special Olympics sports (see below for restrictions or limitations).	
Additional Licensed Examiner Notes:	
Signature	Date
Printed Name	Email
Phone ( )	License

FURTHER MEDICAL EVALUATION

Examiner's Name	Specialty
I have examined this athlete for the following medical concern(s): *Please describe.*	
❍ **YES** ❍ **NO** In my professional opinion, this athlete may participate in Special Olympics sports (see below for restrictions or limitations).	
Additional Licensed Examiner Notes:	
Signature	Date
Printed Name	Email
Phone ( )	License

FURTHER MEDICAL EVALUATION

Examiner's Name	Specialty
I have examined this athlete for the following medical concern(s): *Please describe.*	
❍ **YES** ❍ **NO** In my professional opinion, this athlete may participate in Special Olympics sports (see below for restrictions or limitations).	
Additional Licensed Examiner Notes:	
Signature	Date
Printed Name	Email
Phone ( )	License