

Athlete Medical Form – HEALTH HISTORY

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

**Special
Olympics
Nebraska**



REGION/AREA:

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:

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	Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):		
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	Epilepsy or any type of seizure disorder	No	Yes
If yes, is this new or worse in the past 3 years?	No	Yes	If yes, list seizure type:		
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	No	Yes	If yes, had seizure during the past year?	No	Yes
If yes, is this new or worse in the past 3 years?	No	Yes	Self-injurious behavior during the past year	No	Yes
Head Tilt	No	Yes	Aggressive behavior during the past year	No	Yes
If yes, is this new or worse in the past 3 years?	No	Yes	Depression (diagnosed)	No	Yes
Spasticity	No	Yes	Anxiety (diagnosed)	No	Yes
If yes, is this new or worse in the past 3 years?	No	Yes	Describe any additional mental health concerns:		
Paralysis	No	Yes			
If yes, is this new or worse in the past 3 years?	No	Yes			

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
--	--------------------------------	--------------	--------------

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 ₂ 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 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:

Athlete Medical Form – MEDICAL REFERRAL FORM

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

**Special
Olympics**
Nebraska



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