Athlete Medical Form – HEALTH HISTORY

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

Special Olympics Illinois

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 or has a change in their guardianship status then a Special Olympics Illinois C onsent Form must be submitted with the Medical Form.

ATHLETE INFORMATION

Athle te Last Name:__ _____ Athlete First Na me:__ _____

Preferred Name: _____ _____ Athle te Date o f Birth (mm/dd/yyyy): _____

Athlete Gender Identity: Female Male Other

Athlete Ethnicity 5 D F:H

Asian

American Indian/Alaskan Native

Black/African American

+ L V S D Q L F / D W L Q R

Native Hawaiian/Other Pacific Islander

W :hite

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 ,I WKH DQVZHU WR HLWKHU TXHVWLRQ LV <HV 6SHFLDO 2O\PSLFV ,OOLQR UHVSRQVLEOH SDUHQW JXDUGLDQ

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: _____-_____-_____

Athlete Medical Form – **HEALTH HISTORY**

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

Special Olympics Illinois

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 Brian 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 adminster 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_2Sat	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	
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	NA
Left Tympanic Membrane	Clear	Perforation	Infection	NA
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	Yes	No			
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 below			
Spasticity	No	Yes, describe below			
Tremor	No	Yes, describe below			
Neck & Back Mobility	Full	Not full, describe below			
Upper Extremity Mobility	Full	Not full, describe below			
Lower Extremity Mobility	Full	Not full, describe below			
Upper Extremity Strength	Full	Not full, describe below			
Lower Extremity Strength	Full	Not full, describe below			
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	O_2 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**