

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> White |
| <input type="checkbox"/> Two or More Races | <input type="checkbox"/> Other | <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	<input type="checkbox"/> Heart Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	<input type="checkbox"/> Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	<input type="checkbox"/> Ever had abnormal EKG	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Pacemaker	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	<input type="checkbox"/> Ever had abnormal Echo	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	<input type="checkbox"/> Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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
COPD No Yes Treated in past 12 months
Uses an Inhaler No Yes Treated in past 12 months
Sleep Apnea (C-PAP Machine) No Yes Treated in past 12 months
Other: _____ No Yes Treated in past 12 months

MENTAL HEALTH (check all that apply)

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

OTHER MEDICAL CONDITIONS (check all that apply)

Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Heat Exhaustion	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	Syncope	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Heat Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Colostomy	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	Sickle Cell Trait/Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
G-Tube or J-Tube	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	Seizure Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months
Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Treated in past 12 months	Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Numbness or tingling in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weakness in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head Tilt	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spasticity	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> 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) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	Bowel Sounds <input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	Hepatomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
Right Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Splenomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
Left Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Abdominal Tenderness <input type="checkbox"/> No <input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ
Right Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA	Kidney Tenderness <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left
Left Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA	Right upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Oral Hygiene <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Left upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Thyroid Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes	Right lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Lymph Node Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes	Left lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Heart Murmur (supine) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater	Abnormal Gait <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Murmur (upright) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater	Spasticity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Tremor <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Lungs <input type="checkbox"/> Clear <input type="checkbox"/> Not clear	Neck & Back Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Right Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Upper Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Left Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Lower Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Radial Pulse Symmetry <input type="checkbox"/> Yes <input type="checkbox"/> R>L <input type="checkbox"/> L>R	Upper Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Cyanosis <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	Lower Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Clubbing <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	Loss of Sensitivity <input type="checkbox"/> No <input type="checkbox"/> 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:
- | | | |
|--|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam | <input type="checkbox"/> Acute Infection | <input type="checkbox"/> O ₂ Saturation Less than 90% on Room Air |
| <input type="checkbox"/> Concerning Neurological Exam | <input type="checkbox"/> Stage II Hypertension or Greater | <input type="checkbox"/> Hepatomegaly or Splenomegaly |
| <input type="checkbox"/> Other, please describe: _____ | | |

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- | | | |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist | <input type="checkbox"/> Follow up with a neurologist | <input type="checkbox"/> Follow up with a primary care physician |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist |
| <input type="checkbox"/> Other/Exam Notes: _____ | | |

Signature of Licensed Medical Examiner	Exam Date	Name: _____
		E-mail: _____
		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