# Athlete Medical Form – **HEALTH HISTORY**

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

Special Olympics Illinois

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

**Region** J **Primary Agency Name** Without Limits-Team Galaxy **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 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**
- ☐ **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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**(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 | $O_2$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 | | |
| 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
- ☐ 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's Notes and Recommended (but not required) Follow-up:

- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ 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
- ☐ 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** |
|---|---|
| | |