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 _____ **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:

- ☐ **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:** _____-_____-_____

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
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	☐ 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
- ☐ 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**