# Athlete Medical Form – **HEALTH HISTORY**

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

**REGION/AREA:** LORAIN COUNTY / AREA 12

**DELEGATION/TEAM:** MURRAY RIDGE (RAIDERS)

## 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:

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**(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

*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

**Describe any past broken bones or dislocated joints** *(if yes is checked for either of those fields above)*:

**Epilepsy or any type of seizure disorder** ☐ No ☐ Yes

*If yes, list seizure type:*

*If yes, had seizure during the past year?* ☐ No ☐ Yes

**Self-injurious behavior during the past year** ☐ No ☐ Yes

**Aggressive behavior during the past year** ☐ No ☐ Yes

**Depression (diagnosed)** ☐ No ☐ Yes

**Anxiety (diagnosed)** ☐ No ☐ Yes

**Describe any additional mental health concerns:**

**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 / in | kg / lbs | BMI / Body Fat % | C / F | | | BP Right: / BP Left: | Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A<br>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 | | | | | |

## 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 RELEASE FORM

Special Olympics Murray Ridge

I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.

2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.

3. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.

4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment.
   ☐ I consent to emergency medical care, but I do not consent to blood transfusions.
   (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Special Olympics athletes (identifying information removed if shared publically); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and change my information. I can ask to limit how my information is used.

7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

**ATHLETE NAME:** _____

**ATHLETE SIGNATURE** (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ Date: _____

**PARENT/GUARDIAN SIGNATURE** (required if under 18 years old or has a legal guardian)

I am a parent or guardian of the Athlete. I have read and understand this form and have explained the contents to the Athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Athlete.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____