Athlete Medical Form

Accessibility Version

Special Olympics Hawai'i

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

First name: _____ Last name: _____

Preferred name: _____ Date of birth (mm/dd/yyyy): ____/____/_____

Gender: Female ☐ Male ☐ Other ☐ Email: _____

Phone number: _____ Mobile ☐ Landline ☐

Postal address: _____

Country: _____

Emergency Contact

First name: _____ Last name: _____

Phone number: _____ Mobile ☐ Landline ☐

Relationship to athlete: Parent/guardian ☐ Caregiver ☐ Family member ☐ Healthcare provider ☐ Coach ☐ Other ☐

Qualifying and Associated Conditions - *Check all that apply:*

Associated Conditions:

- ☐ Autism
- ☐ Down Syndrome
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Fragile X Syndrome
- ☐ Fetal Alcohol Syndrome
- ☐ Spina Bifida
- ☐ Marfan Syndrome
- ☐ Other
- ☐ None

Please specify other known intellectual disability:

Assistive Devices and Accommodations - *Do you use any of the following? (Check all that apply):*

Mobility:

- ☐ Walker
- ☐ Braces or crutches
- ☐ Wheelchair
- ☐ Prosthetics
- ☐ Removable orthotics
- ☐ None

Lifestyle Aids:

- ☐ CPAP
- ☐ Colostomy
- ☐ Dentures
- ☐ Inhaler
- ☐ Glasses or contact lenses or protective eye wear
- ☐ None

Communications:

- ☐ Hearing aid
- ☐ Communication devices
- ☐ Sign language
- ☐ None

Medical Devices:

- ☐ Implantable cardioverter defibrillator (ICD)
- ☐ VP shunt
- ☐ Implantable device for seizure management
- ☐ Pacemaker
- ☐ Spinal cord stimulator
- ☐ None

List specific dietary requirements:

Other assistive devices and accommodations:

General Health Questions - *Have you ever been diagnosed with or experienced any of the following?*

High blood pressure	Yes ☐	No ☐	Heat illness	Yes ☐	No ☐
Cardiac condition	Yes ☐	No ☐	Coeliac disease	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Enlarged spleen	Yes ☐	No ☐
Kidney disease	Yes ☐	No ☐	Hearing impairment	Yes ☐	No ☐
Bleeding disorders	Yes ☐	No ☐	Visual impairment	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Non-verbal	Yes ☐	No ☐

Have you ever had a head injury or concussion?.....	Yes ☐	No ☐
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?.....	Yes ☐	No ☐
Has any family member or relative died of heart problems or of sudden death before age 50?.....	Yes ☐	No ☐
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?.....	Yes ☐	No ☐
Have you had COVID-19?.....	Yes ☐	No ☐
Have you been immunized for COVID-19?.....	Yes ☐	No ☐

Do you have an allergy to any of the following?

Dust ☐	Foods ☐	Insects ☐	Animals ☐
Plants ☐	Grasses ☐	Pollen ☐	Drugs or medicine ☐
Latex ☐	Other ☐	None ☐	

Please specify allergies:

Have you had any surgeries?	Yes ☐	No ☐	If yes, please list all:
Did you ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	Yes ☐	No ☐	If yes, please specify:
Has a doctor ever limited your participation in sports?	Yes ☐	No ☐	If yes, please specify:
Do you have epilepsy or any type of seizure disorder?	Yes ☐	No ☐	If yes, please specify:
Have you had any broken bones or dislocated joints?	Yes ☐	No ☐	If yes, please specify:
Do you have liver disease?	Yes ☐	No ☐	If yes, please specify:

Do you have lung disease?	Yes ☐	No ☐	If yes, please specify:
Do you have heart disease?	Yes ☐	No ☐	If yes, please specify:
Do you have behavioral, mental health, and/or sensory conditions?	Yes ☐	No ☐	If yes, please specify:

Medication and Treatment - *Please list:*

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins, allergy shots or pills, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.) Please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Eligibility to Participate

Every person with an intellectual disability who is at least eight years of age is eligible to participate in Special Olympics. A person is considered to have an intellectual disability for purposes of determining his or her eligibility to participate in Special Olympics if that person satisfies any one of the following requirements:

(1) The person has been identified by an agency or professional as having an intellectual disability as determined by their localities; or

(2) The person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted within the professional community in that Accredited Program's nation as being a reliable measurement of the existence of a cognitive delay; or

(3) The person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as IQ) and in adaptive skills (such as in recreation, work, independent living, self-direction, or self-care).

However, persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes, but may be eligible to volunteer for Special Olympics.

Today's date (mm/dd/yyyy): **____/____/_____**

Signature of person completing the form: _____

Is this form being completed by someone other than the athlete? Yes ☐ No ☐

If form is being completed by someone other than the athlete, please select the relationship to athlete.

Relationship to athlete:

Parent/Guardian ☐ Caregiver ☐ Family Member ☐

Healthcare Provider ☐ Coach ☐ Other ☐

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications.

Athlete first and last name: _____

Date of birth (mm/dd/yyyy): _____/_____/_____

Height (in or cm)		Pulse (bpm)	
Weight (lb or kg)		O2sat (%)	
Waist circumference (in or cm)		Blood pressure (mmHg)	/
Temperature (°F or °C)		Vision	os _____/20 od _____/20

Medical

Eyes, ears, nose, and throat: include pupils, hearing	Normal ☐	Abnormal ☐	Findings:	
Heart: include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)	Normal ☐	Abnormal ☐	Findings:	
Lungs	Normal ☐	Abnormal ☐	Findings:	
Abdomen	Normal ☐	Abnormal ☐	Findings:	
Skin: HSV, MRSA, or tinea corporis	Normal ☐	Abnormal ☐	Findings:	
Neurological	Normal ☐	Abnormal ☐	Findings:	

Musculoskeletal

Neck	Normal ☐	Abnormal ☐	Findings:
Back	Normal ☐	Abnormal ☐	Findings:
Shoulder and arm	Normal ☐	Abnormal ☐	Findings:
Elbow and forearm	Normal ☐	Abnormal ☐	Findings:
Wrist, hand, and fingers	Normal ☐	Abnormal ☐	Findings:
Hip and thigh	Normal ☐	Abnormal ☐	Findings:
Knee	Normal ☐	Abnormal ☐	Findings:
Lower leg and ankle	Normal ☐	Abnormal ☐	Findings:
Foot and toes	Normal ☐	Abnormal ☐	Findings:

Is there anything else Special Olympics should know about the health or wellbeing of this athlete?

Use additional pages if necessary.

MEDICAL ELIGIBILITY FOR SPORT (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 provide information regarding the licensed healthcare provider below. That provider should complete a referral below and second physician for referral should complete the Athlete Physical Information portion.

☐ Medically eligible for all sports without restriction.

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____

☐ Not medically eligible to participate in the following sports:

_____

☐ Not medically eligible pending further evaluation of:

_____

☐ Not medically eligible for any sports

I have examined the athlete named on this form and completed the pre-participation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional: _____

Date (mm/dd/yyyy): _____/_____/_____ Phone number: _____

Address: _____

Signature: _____

NPI or License number: _____ License type (MD, DO, NP, or PA): _____

Doctor/Office stamp required!