Athlete Medical Form

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 Cerebral Palsy Down Syndrome Epilepsy Fragile X Syndrome Fetal Alcohol Syndrome Spina Bifida Marfan Syndrome Other None
Please specify other known intellectual disability diagnoses	

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, contact lenses, or protective eyewear None
Communications	Hearing aid Communication devices Sign language None
Medical Devices	Implantable cardioverter defibrillator (ICD) Implantable device for seizure management VP shunt Spinal cord stimulator Pacemaker 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 disorder	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	Food	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

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

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. <u>If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.</u>

Athlete first and last name: ______________________________ Date of birth (mm/dd/yyyy): _____/_____/________

Height (in/cm)	**Weight (lb/kg)**	**Waist circumference (in/cm)**	**Temperature (°F/°C)**	**Pulse (bpm)**	**O2Sat (%)**	**Blood pressure (mmHG)**		**Vision (out of 20)**	
						systolic	diastolic	os	od

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:

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 page 4.

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 pending further evaluation of: ________________________________

Not medically eligible to participate in the following sports: ________________________________

Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation 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 (print or type): ______________________________ Date (mm/dd/yyyy): ____/____/_____

Address: ______________________________ Phone: ____________________

Signature of health care professional: ______________________________ **Doctor/Office stamp required!**

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