Athlete Medical Form

Special Olympics

The form consists of two sections.
Section 1: *Mandatory* for all Athletes participating in Special Olympics activities, including one day sporting events, practices, and competitions to complete. For overnight Special Olympics Events or Games, Section 2: *must* be completed by a licensed medical professional authorized under the laws of the Accredited Program's jurisdiction.

Complete form using block capital letters.

Section 1: All Athletes Complete

To be completed by the athlete or parent/guardian/caregiver.

First name: _____ Last name: _____ Preferred name: _____

Date of birth (dd/mm/yyyy):_____/_____/_____ Gender: ◯ Female ◯ Male ◯ Other

Email: _____ Phone number: _____ ◯ Mobile ◯ Landline

Home address: _____ Country: _____

Emergency Contact

First name: _____ Last name: _____ Phone number:_____ ◯ Mobile ◯ Landline

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

Associated Conditions - *Mandatory*

Associated Conditions ***Check all that apply:***	☐ Autism ☐ Marfan Syndrome ☐ Other	☐ Cerebral Palsy ☐ Spina Bifida ☐ Unknown	☐ Down Syndrome ☐ Epilepsy	☐ Fetal Alcohol Syndrome ☐ Fragile X Syndrome
Please specify other known intellectual disability diagnoses:				

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

Mobility	☐ Walker ☐ Prosthetics	☐ Braces or crutches ☐ None	☐ Wheelchair	☐ Removable orthotics
Lifestyle Aids	☐ CPAP ☐ Glasses, contact lenses, or protective eyewear	☐ Colostomy	☐ Inhaler ☐ None	☐ Dentures
Communications	☐ Hearing aid	☐ Communication devices	☐ Sign language	☐ None
Medical Devices	☐ Implantable cardioverter defibrillator (ICD) ☐ VP shunt	☐ Spinal cord stimulator	☐ Implantable device for seizure management ☐ Pacemaker	☐ None

Do you have a specific dietary requirement?	◯ Yes	◯ No	If yes, please specify:
Do you use other assistive devices?	◯ Yes	◯ No	If yes, please specify:

Athlete first and last name:_____

General Health Questions

Do you have a heart condition?	◯ Yes	◯ No
Do you have asthma?	◯ Yes	◯ No
Do you have diabetes that requires you to take insulin?	◯ Yes	◯ No
Do you have a vision impairment?	◯ Yes	◯ No
Do you have a hearing impairment?	◯ Yes	◯ No
Do you have a bleeding disorder?	◯ Yes	◯ No
Has a doctor ever limited your participation in sports?	◯ Yes	◯ No
Do you have epilepsy or any type of seizure disorder?	◯ Yes	◯ No
Do you have sickle cell disease?	◯ Yes	◯ No

Have you ever had a concussion?	◯ Yes ◯ No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	◯ Yes ◯ No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	◯ Yes ◯ No	If yes, please specify if it is to any of the following: ☐ Insect stings ☐ Medication/drugs ☐ Food ☐ Latex ☐ Other (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, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

◯ Yes ◯ No

If yes, please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

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

Name/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

Section 2: For completion for Games and/or Overnight Events

Medical Physical Examination - *To be completed by examiner only.*

To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name:_____ Date of birth (dd/mm/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

Does the athlete present with any of the following?									
High Blood Pressure	◯ Yes	◯ No		Coeliac Disease	◯ Yes	◯ No	◯ Unknown
Kidney Disease	◯ Yes	◯ No	◯ Unknown	Osteoporosis	◯ Yes	◯ No	◯ Unknown
Anemia	◯ Yes	◯ No	◯ Unknown	Non-verbal	◯ Yes	◯ No	

Has any family member or relative died of heart problems or of sudden death before age 50?	◯ Yes	◯ No
Was the athlete born without or missing a kidney, an eye, a testicle, or any other organ?	◯ Yes	◯ No

Does the athlete have any past surgeries?	◯ Yes	◯ No	◯ Unknown	If yes, please list all:
Did the athlete ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	◯ Yes	◯ No	◯ Unknown	If yes, please specify:
Did the athlete ever have any broken bones or dislocated joints?	◯ Yes	◯ No	◯ Unknown	If yes, please specify:
Does the athlete have liver disease?	◯ Yes	◯ No	◯ Unknown	If yes, please specify:
Does the athlete have lung disease?	◯ Yes	◯ No	◯ Unknown	If yes, please specify:
Does the athlete have heart disease?	◯ Yes	◯ No	◯ Unknown	If yes, please specify:

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:

Athlete first and last name_____

Medical Physical Examination - *To be completed by examiner only.*

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 (dd/mm/yyyy):___/___/_____

Address:_____ Phone: _____

Signature of health care professional: _____

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

Zwrot do 15 sierpnia 2024 na adres: Olimpiady Specjalne Polska, ul. Leszno 21, 01-199 Warszawa tel. 604 208 279