Athlete Medical Form

This application expires three (3) years from the date of the physical exam.

AREA: Four Peaks

DELEGATION(TEAM): Gilbert Roadrunners

EMERGENCY CONTACT:

EMERGENCY PHONE:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date Birth *(mm/dd/yyyy)* : Female: ☐ Male: ☐

Address:

City: Zip:

Phone: Cell:

E-mail: Eye color:

I am my own guardian. ☐ Yes ☐ No

☐ PARENT ☐ GUARDIAN INFORMATION

Name:

Phone: Cell:

E-mail:

Athlete's Primary Care Physician:

Phone:

Primary Care Physician Address:

City: Zip:

Does the athlete have (check any that apply):

☐ Autism ☐ Down syndrome ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome

☐ Other syndrome, please specify:

List any sports the athlete wishes to play:

Is the athlete allergic to any of the following (please list):

☐ Food:

☐ Medications:

☐ Insect Bites or Stings:

☐ Latex ☐ No Known Allergies

Does the athlete use (check any that apply):

☐ Dentures ☐ Communication Device ☐ Wheel Chair

☐ Brace ☐ Removable Prosthetics ☐ Crutches or Walker

☐ Splint ☐ Glasses or Contacts ☐ Hearing Aid

☐ Pacemaker ☐ G-Tube or J-Tube ☐ Implanted Device

☐ Inhaler ☐ Colostomy ☐ C-PAP Machine

List all past surgeries:

List any special dietary needs:

List all ongoing or past medical conditions:

List all medical conditions that run in the athlete's family:

Does the athlete have any religious objections to medical treatment?

☐ No ☐ Yes

Has any relative died of a heart problem before age 40? ☐ No ☐ Yes

Has any family member or relative died while exercising? ☐ No ☐ Yes

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)?

☐ No ☐ Yes *If yes, please describe:*

Has a doctor ever limited the athlete's participation in sports? ☐ No ☐ Yes

If yes, please describe:

Has the athlete ever had an abnormal Echocardiogram (Echo)? ☐ No ☐ Yes

If yes, please describe:

Has the athlete been vaccinated against COVID-19? ☐ No ☐ Yes

Has the athlete had a Tetanus vaccine within the past 7 years? ☐ No ☐ Yes

Athlete Name: _____

PLEASE INDICATE IF THE ATHLETE HAS EVER HAD 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 heat 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		
Endocarditis	☐ No ☐ Yes	Dislocated Joints	☐ No ☐ Yes		

Any 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

Please describe any past broken bones or dislocated joints:

Epilepsy or any type of seizure disorder	☐ No	☐ Yes
If yes, list seizure type:		
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	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes

Please describe any additional mental health concerns:

Ethnic Background-This is solely to help us comply with government record keeping, reporting, and legal requirements:

☐ White
☐ Latino/Hispanic
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Pacific Islander

Health Insurance Provider:

☐ American Indian Health Program
☐ Arizona Complete Health - Complete Care Plan
☐ Banner-University Family Care
☐ Care1st Health Plan
☐ Molina Complete Care
☐ Mercy Care
☐ Health Choice Arizona
☐ UnitedHealthcare Community Plan
☐ Uninsured
☐ Other _____

Insurance Policy Number _____

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, list the date of the athlete's last menstrual period:**

Athlete Signature **Date** **Legal Guardian Signature** **Date**

Athlete Name:

MEDICAL PHYSICAL INFORMATION *(TO BE COMPLETED BY EXAMINER ONLY)*

Height	Weight	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
cm	kg	C			BP Right	BP Left	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A
in	lbs	F					Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	Bowel Sounds	☐ No	☐ Yes		
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	Hepatomegaly	☐ No	☐ Yes		
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	Splenomegaly	☐ No	☐ Yes		
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ ☑ LLQ
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	Kidney Tenderness	☐ No	☐ Right	☐ Left	
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Oral Hygiene	☐ Good	☐ Fair	☐ Poor	Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Thyroid Enlargement	☐ No	☐ Yes		Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Lymph Node Enlargement	☐ No	☐ Yes		Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia	
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	Abnormal Gait	☐ No	☐ Yes, describe		
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	Spasticity	☐ No	☐ Yes, describe		
Heart Rhythm	☐ Regular	☐ Irregular		Tremor	☐ No	☐ Yes, describe		
Lungs	☐ Clear	☐ Not clear		Neck & Back Mobility	☐ Full	☐ Not full, describe		
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	Upper Extremity Mobility	☐ Full	☐ Not full, describe		
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	Lower Extremity Mobility	☐ Full	☐ Not full, describe		
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R	Upper Extremity Strength	☐ Full	☐ Not full, describe		
Cyanosis	☐ No	☐ Yes, describe		Lower Extremity Strength	☐ Full	☐ Not full, describe		
Clubbing	☐ No	☐ Yes, describe		Loss of Sensitivity	☐ No	☐ Yes, describe		

Does athlete have neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and must therefore receive an additional neurological evaluation to rule out the risk of spinal cord injury prior to clearance for sports participation?
☐ No ☐ Yes

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 is deemed to need further medical evaluation please utilize the Special Olympics Further Medical Evaluation Form, page 4, in order to provide the athlete with medical clearance.

☐ **This athlete <u>is able to</u> participate in Special Olympics sports. (Use Additional Licensed Examiner Notes for any restrictions or limitations).**

☐ **This athlete <u>may not</u> participate in Special Olympics sports at this time and must be 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:

☐ 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:

Licensed Medical Examiner's Signature **Date of Exam**

Name:
E-mail:
Phone: License:

Athlete Name:

FURTHER MEDICAL EVALUATION FORM *(Only to be used if the athlete has previously not been cleared for sports participation above)*

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete:
☐ Yes ☐ No May participate in Special Olympics sports (see below for restrictions or limitations)
☐ Additional Examiner Notes:

E-mail:

Phone:

License:

Examiner's Signature **Date**

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete:
☐ Yes ☐ No May participate in Special Olympics sports (see below for restrictions or limitations)
☐ Additional Examiner Notes:

E-mail:

Phone:

License:

Examiner's Signature **Date**

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete:
☐ Yes ☐ No May participate in Special Olympics sports (see below for restrictions or limitations)
☐ Additional Examiner Notes:

E-mail:

Phone:

License:

Examiner's Signature **Date**

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete:
☐ Yes ☐ No May participate in Special Olympics sports (see below for restrictions or limitations)
☐ Additional Examiner Notes:

E-mail:

Phone:

License:

Examiner's Signature **Date**

OFFICIAL SPECIAL OLYMPICS CONSENT FORM

Athlete Name: First _____ **Last** _____

D.O.B.: _____

RELEASE TO BE COMPLETED BY PARENT/GUARDIAN OR ADULT ATHLETE (OWN GUARDIAN)

THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED, AND DATED TO BE CONSIDERED VALID FOR THREE (3) YEARS

I, the Parent/Guardian or Adult Athlete submits this Official Special Olympics Release Form for participation in Special Olympics.

Section 1

I represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical examiner (MD/DO/NP/PA-C) has reviewed the health information contained in the application for participation and has certified, based on a medical examination, that there is no medical evidence which would preclude the athlete from participating in Special Olympics.

Section 2

I understand that if the athlete has Down syndrome, the athlete cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine unless the athlete and medical examiner have completed the official "Down syndrome Addendum Form", available from the Special Olympics State Office. I am aware that the x-ray exam is required before any athlete with Down syndrome may participate in equestrian, gymnastics, judo, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and soccer.

Section 3

Special Olympics has my permission, both during and any time after, to use the athlete's likeness, name, voice or words in either television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

Section 4

If during the athlete's participation in Special Olympics activities, the athlete should need emergency medical treatment, and I (the parent/guardian or adult athlete) am not able to give consent or make arrangements for that treatment, I authorize Special Olympics to take whatever measures necessary to protect the athlete's health and well-being, including if necessary, hospitalization.

Section 5

I understand by signing below, that I consent to participate in the **Special Olympics Healthy Athletes Program** that provides individuals screening assessments of health status and health care needs in the areas of vision, oral health, hearing, physical therapy, and a variety of health promotion areas. I understand there is no obligation for the athlete to participate in the Healthy Athletes Program and that the athlete may decide not to participate. Provisions of these health services are not intended as a substitute for regular care. I also understand that I should seek independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not responsible for the health of the athlete. I understand that information gathered as part of the screening process may be used anonymously to assess and communicate overall health and needs of athletes and to develop programs to address those needs.

Section 6

I understand the nature and risk of concussion and head injuries, including the risks of continuing to play after concussion or head injury. I acknowledge that Special Olympics has a concussion awareness and safety recognition policy that may require an athlete to seek medical attention from a medical professional in the event of a suspected concussion. Any athlete suspected of sustaining a concussion will not be permitted to return to Special Olympics sports activities until written medical clearance is provided and at least 7 days have passed since the date of the suspected injury. I further acknowledge that additional information regarding concussions may be found on the Centers for Disease Control Heads Up website at http://www.cdc.gov/headsup/youthsports/index.html.

To be completed by Adult Athlete (own Guardian)

I, the adult athlete, have read this form and fully understand the provisions of the release that I am signing. I acknowledge that I have read and agree to the Athlete Code of Conduct and the Code of Conduct Compliance Policy. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature _____

Print Name _____

Date: _____/_____/_____

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Signature _____

Print Name _____

OR

To be completed by Parent/Guardian

I, the Parent/Guardian of this athlete, hereby give my permission for this athlete to participate in Special Olympics games, training, recreation programs, physical activity programs and Healthy Athletes program. I acknowledge I have read and agree to the Athlete Code of Conduct and the Code of Conduct Compliance Policy. By signing, I am saying that I agree to the provisions of this release.

Signature _____

Print Name _____

Date: _____/_____/_____