Partner Medical Form

Special Olympics Arizona

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

REGION: North America

DELEGATION/TEAM: Gilbert Roadrunners

☐ MedFest®
☑ Unified Partner (Medicals Optional)
☐ Individual Physical
☐ Healthy Young Athletes

PARTNER INFORMATION

First Name: | Middle Name:

Last Name:

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

Address:

Phone: | Cell:

E-mail: | Eye color:

I am my own guardian. ☐ Yes ☐ No

☐ PARENT ☐ GUARDIAN INFORMATION

Name:

Phone: | Cell:

E-mail:

Partners's Primary Care Physician:

Phone:

Primary Care Physician Address:

Does the partner have (check any that apply):

☐ ADHD ☐ Diabetes

☐ Migranes

☐ Other syndrome, please specify:

List any sports the partner wishes to play:

Is the partner allergic to any of the following (please list): ☐ Food:

☐ Medications:

☐ Insect Bites or Stings:

☐ Latex ☐ No Known Allergies

Does the partner 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 family:

Does the partner have any religious objections to medical treatment?

☐ No ☐ Yes *If yes, please complete the religious objections form.*

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 partner currently have any chronic or acute infection?

☐ No ☐ Yes *If yes, please describe:*

Has the partner ever had an abnormal Electrocardiogram (EKG)?

☐ No ☐ Yes *If yes, please describe:*

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

If yes, please describe:

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

Partner Name: _____

PLEASE INDICATE IF THE PARTNER 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

Additional Questions:

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:

Additional Questions:

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

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

Health Insurance information:

Healthcare provider_____

Policy Number _____

Emergency Contact information_____

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:**

Partner Signature **Date** **Legal Guardian Signature** **Date**

Special Olympics Arizona

Youth Unified Partner (Under 18)

- This form must be completed and an approval letter received before any Youth/Unified Partner participates in a Special Olympics activity.

Part 1 - General Information (please print)

DELEGATION: Gilbert Roadrunners CONTACT: _____

First: _____ Middle: _____ Last: _____

Registered Address: _____ City: _____ , AZ Zip Code: _____

Gender: ○ Female ○ Male DOB: _____ Age: 0 School: _____

Parent/Guardian: _____ Day Phone: _____

E-mail: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Medical History (Please list all allergies and medical conditions): _____

_____

Part 2 - Special Olympics Release and Waiver of Liability

- In consideration of participating in Special Olympics Unified Sports®, I represent I understand the nature of the event and I am qualified, in good health, and in proper physical condition to participate in Unified Sports® events. I fully understand the event involves risks of serious bodily injury which may be caused by my own actions or inactions, by the actions of others participating in the event, or by conditions in which the event takes place. I fully accept and assume all such risks and all responsibility for losses, costs, and/or damages I participation. I acknowledge at any time I feel the event conditions are unsafe, I will discontinue participation immediately.

- If during my participation in Special Olympics activities, I should need emergency medical treatment and I am not able to give my consent for or make my own arrangements for treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

- I release, indemnify, covenant not to sue, and hold harmless Special Olympics, its administrators, directors, agents, officers, volunteers, employees, and other Unified Sports® participants, and sponsors, advertisers, and if applicable, any owners and lessors of premises on which the activity takes place from all liability, any loses, claims (other than that of the medical accident benefit), demands, costs, or damages I may incur as a result of participation in Unified Sports® events and further agree if despite this "Release and Waiver of Liability, Assumption of Risk, and Indemnity Agreement", I or anyone on my behalf, makes a claim against any of the Releases, I will indemnify, save, and hold harmless each of the Releases from any litigation expenses, attorney fees, loss, liability, damage or cost which may incur as a result of such claim.

-I have read and agree to the correct code of conduct which refers to the volunteer position I am applying for (ex: Coaches Code of Conduct, Volunteer Code of Conduct, Unified Code of Conduct,Code of Conduct Compliance Policy etc.)

- I, the Parent/Guardian of this youth volunteer, hereby give my permission for this youth volunteer to participate in Special Olympics games, training, recreation programs and physical activity program. By signing, I agree to the provisions of this release.

- 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/partner to seek medical attention from a medical professional in the event of a suspected concussion. Any athlete/partner 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

x _____
Guardian Signature *Print Name* *Date*

Part 3 - HOD/ Head Coach Reference

By signing, I confirm the following: I know _____ (Name of Applicant) in either a personal or professional capacity. I am at least 18 years of age and am not a legal guardian or relative of the applicant. I am not aware of any reason the applicant should not be permitted to volunteer on behalf of Special Olympics. I do not possess any information which would cause me to believe the applicant would pose any undue risk to Special Olympics athletes or others who participate in Special Olympics.

_____ _____
HOD/Head Coach Signature Date

Please submit application to your local head of delegation/head coach.
www.SpecialOlympicsArizona.org