ATHLETE MEDICAL FORM

Special Olympics Kentucky

Special Olympics State Program:_____

Are you a new athlete to Special Olympics or Re-Registering? ☐ New Athlete ☐ Re-Registering

ATHLETE INFORMATION		
First Name:	**Middle Name:**	
Last Name:	**Preferred Name:**	
Date Birth (mm/dd/yyyy):	☐ Female ☐ Male ☐ Other	
☐ **Race/Ethnicity:** ☐ American Indian/Alaskan Native ☐ Black or African American ☐ White	☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino (specific origin group: _____) ☐ Middle Eastern/North African	☐ Two or More Races
Language(s) Spoken in Athlete's Home (Optional): Check all that apply ☐ English ☐ Spanish ☐ Other (please list):		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? ☐Yes ☐ No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
☐ **Same Contact Info as Athlete**		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
EMERGENCY CONTACT INFORMATION		
☐ **Same as Parent/Guardian**		
Name:		
Phone:	**Relationship:**	
PHYSICIAN / INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

Return Completed Medical To:
SOKY/Medical
105 Lakeview Ct.
Frankfort, KY 40601

ATHLETE MEDICAL - RELEASE FORM

Special Olympics Kentucky

Athlete First and Last Name: _____

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics to use my photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics. For this form, "Special Olympics" means all Special Olympics organizations.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
   - ☐ I have a religious or other objection to receiving medical treatment.
   - ☐ I do not consent to blood transfusions.

   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics is collecting my personal information.
   - I consent to Special Olympics using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related operations and activities; and provide event-related services.
   - I consent to Special Olympics using my email address and creating a profile of me for communications and marketing purposes.
   - I understand that Special Olympics may disclose my personal information to medical professionals in the event of an emergency and to third party researchers to analyze data for the purposes of improving Special Olympics programming and identifying and responding to the needs of Special Olympics participants.
   - I understand that Special Olympics may disclose my personal information to government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I understand Special Olympics is a global organization with headquarters in the United States of America. I consent to Special Olympics storing and processing my personal information in countries, including the United States of America, that have laws requiring a different level of privacy and data protection.
   - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to make changes to or delete my information.

ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)

I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.

Athlete Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)

I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Athlete Medical Form

Special Olympics Kentucky

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:*

Degree of Disability	Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Unknown ☐ None ☐
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 ☐

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. 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 (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: _____

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