



Medical Form

Section A should be submitted every three (3) years - staple to original with doctor's signature.

Section A - ATHLETE HEALTH INFORMATION

County Program: _____

Athlete Social Security Number _____ - _____ - _____

Athlete Name _____

Address _____

Parent/Guardian Name _____

Address (if different than athlete) _____

Emergency Contact (if other than parent/guardian) _____

Health/Accident Company _____

Sex/Gender M F Date of Birth (month/day/year) _____/_____/_____

Home Phone _____

Work Phone _____

Home Phone _____

Home Phone _____

Policy # _____

	YES	NO	New Problem
1. Heart Disease/Heart Defect/High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Chest Pain or Fainting Spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures/Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Down Syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have cervical spine (neck bone) x-rays been done.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atlantoaxial Instability.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Parent/Sibling (under 40) died of heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Absence of vision/blind in one eye.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Absence of one kidney or testicle.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Concussion or serious head injury.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Major surgery or serious illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Heat Stroke/exhaustion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Other problem that would interfere with sports participation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
13. Impaired motor ability.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Uses a wheelchair.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Allergy to the following (list specific).....	<input type="checkbox"/>	<input type="checkbox"/>
Medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Foods _____	<input type="checkbox"/>	<input type="checkbox"/>
Insect Sting/Bite _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Special Diet _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Exercise induced wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Tendency to bleed easily.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Emotional/psychiatric/behavioral problems.....	<input type="checkbox"/>	<input type="checkbox"/>
20. Serious bone or joint disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
21. Sickle cell trait or disease.....	<input type="checkbox"/>	<input type="checkbox"/>
22. Hearing aid/hearing loss.....	<input type="checkbox"/>	<input type="checkbox"/>
23. Contact lenses/eyeglasses.....	<input type="checkbox"/>	<input type="checkbox"/>
24. Dentures/false teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
25. Immunizations (shots) are up-to-date.....	<input type="checkbox"/>	<input type="checkbox"/>
26. Date of last tetanus shot _____/_____/_____	<input type="checkbox"/>	<input type="checkbox"/>

- A physical examination performed by a licensed examiner is required every 3 years for Athletes with YES in items 1-6.
- An exam is required the first time NEW is checked in items 7-13.

Comments: _____

MEDICATIONS – Please print medication name, amount, date prescribed and number of times per day medication needs to be taken (attach page if needed):

Person completing form (normally parent/guardian or adult athlete) _____/_____/_____
Signature Date

IF HISTORY SIGNED BY ATHLETE—I have reviewed the health history with the athlete whose name appears above.
_____/_____/_____
Signature Date Relationship to Athlete (family member, coach, friend)

IMPORTANT: If there is any significant change in the athlete's health, the athlete's condition should be reviewed by a licensed examiner before further participation.

Section B - MEDICAL CERTIFICATION A physical examination performed by a licensed examiner is required for initial participation

EXAMINER'S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlantoaxial Instability before he/she may participate in sports or events which, by their nature may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football team competition (soccer).

I have reviewed the above health information on and examined the athlete named in the application, and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions: _____

EXAMINER'S SIGNATURE _____

Examiner's Name: _____ Date: _____/_____/_____

Address: _____ Phone: _____