



## **Special Olympics Ohio new Medical and Release Forms**

Special Olympics Incorporated has issued new medical and release forms that State Chapters must begin using. Special Olympics Ohio 2012 (version) medical forms that are dated prior to April 1, 2017 will still be valid for 3 years as of the physician's signature. After this date, all programs must use the new forms that are attached.

### **Please print clearly on this form**

#### **Health History**

Pages 1-2 need to be filled out prior to the athlete's medical examination. The name of person completing pages 1 and 2 needs to be filled out on the bottom of page 2. Please fill out as much information as possible.

Areas on page (1) one that must be filled out include: Athlete's name, age and gender. On page (2) two: athlete's name and person completing the form

#### **Athlete Release Form**

Page 3 is the Athlete Release form this page needs to be filled out and signed by a parent or guardian. If the athlete is signing the form and is over 18 they need to sign at the participant signature line. There are no changes that can be made to the wording on this form for an athlete to be allowed to participate. There must be a signature and date on this form.

#### **Physical Examination**

Make sure the athlete's name is filled out at the top of this form, all information the doctor feels comfortable completing will be accepted. **A doctor's signature and date must be on page 4 of this form, no attached medicals or signatures will be accepted. The doctor must fill out the recommendations area of participation.**

#### **Medical Referral Form**

This page is only to be used if a doctor determines that an athlete needs further examination to a specialist prior to any involvement in Special Olympics.

# Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by the athlete or parent/guardian)



County:

Organization:

## ATHLETE INFORMATION

First Name:  Middle Name:

Last Name:

Date of Birth (mm/dd/yyyy):  Female:  Male:

Address (Street):

Address (City, State, Zip):

Phone:  Cell:

E-mail:

Eye color:  Ethnicity (voluntary):

Athlete Employer, if any:

I am my own guardian.  Yes  No

Does the athlete have (check any that apply):

- Autism
- Down syndrome
- Fragile X Syndrome
- Cerebral Palsy
- Fetal Alcohol Syndrome
- Other syndrome, please specify:

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

Latex  No Known Allergies

Medications:

Insect Bites or Stings:

Food:

List any special dietary needs:

List all past surgeries:

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) or an abnormal Echocardiogram (Echo)? *if yes, select below and describe*

Yes, had abnormal EKG  Yes, had abnormal Echo

## PARENT GUARDIAN INFORMATION (if not own guardian)

Name:

Phone:  Cell:

E-mail:

Emergency Contact Name:  Same as Above:

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the Athlete have a Primary care Physician:  Yes  No *if yes, list*

Physician Name:  Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?  
 No  Yes *if yes, contact your local Program to get the Emergency Care Refusal Form.*

List any sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

No  Yes *if yes, please describe:*

Does the athlete use (check any that apply):

- Brace
- Colostomy
- Communication Device
- C-PAP Machine
- Crutches or Walker
- Dentures
- Glasses or Contacts
- G-Tube or J-Tube
- Hearing Aid
- Implanted Device
- Inhaler
- Pacemaker
- Removable Prosthetics
- Splint
- Wheel Chair

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

## FAMILY HISTORY

Has any relative died of a heart problem before age 50?  No  Yes

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

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

# Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by athlete or parent/guardian/caregiver)



Athlete's Name:

**INDICATE IF THE ATHLETE HAS EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS**

- |  |  |                     |  |                    |  |
|--|--|---------------------|--|--------------------|--|
| Loss of Consciousness                        | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes | Stroke/TIA         | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dizziness during or after exercise           | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Cholesterol    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Concussions        | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Headache during or after exercise            | <input type="checkbox"/> No <input type="checkbox"/> Yes | Vision Impairment   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma             | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chest pain during or after exercise          | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hearing Impairment  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Shortness of breath during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | Enlarged Spleen     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Irregular, racing or skipped heart beats     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Single Kidney       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Urinary Discomfort | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital Heart Defect                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteoporosis        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Spina Bifida       | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Attack                                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteopenia          | <input type="checkbox"/> No <input type="checkbox"/> Yes | Arthritis          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cardiomyopathy                               | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sickle Cell Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heat Illness       | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Valve Disease                          | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sickle Cell Trait   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Broken Bones       | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Murmur                                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Easy Bleeding       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Dislocated Joints  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Endocarditis                                 | <input type="checkbox"/> No <input type="checkbox"/> Yes |                     |  |                    |  |

- 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

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

Epilepsy or any type of seizure disorder  No  Yes

*If yes, list seizure type:*

*If yes, had 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 (diagnosed)  No  Yes

Anxiety (diagnosed)  No  Yes

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

**PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW** (Include 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 athlete, list date of last menstrual period:

Athlete Signature (if over 18 years old)

Date

Legal Guardian Signature (if over 18 years old and not own guardian relating to Athlete)

Date

# ATHLETE RELEASE FORM

Special Olympics



I want to take part in Special Olympics and agree to the following:

- 1. Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.
- 2. Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.
- 3. Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
- 4. Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:
  - I have a religious or other objection to receiving medical treatment.
  - I consent to emergency medical care, but I do not consent to blood transfusions.(If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
- 5. Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.
- 6. Personal Information.** I understand my information may be used and shared by Special Olympics to:
  - Make sure I am eligible and can participate safely;
  - Run trainings and events and share results;
  - Put my information in a computer system;
  - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
  - Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publicly); and
  - Protect health and safety, respond to government requests, and report information required by law.I can ask to see and revise my information. I can ask to limit how my information is used.
- 7. Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

**PARTICIPANT NAME:** \_\_\_\_\_

**PARTICIPANT SIGNATURE** (required if over 18 years old and signing on own behalf)

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

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** (required if under 18 years old or has a legal guardian)

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

# Athlete Medical Form – PHYSICAL EXAM

(to be completed by a Medical Professional only)



Athlete's Name:

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

Height	Weight	BMI (optional)	Temperature	Pulse	O <sub>2</sub> Sat	Blood Pressure	Vision
<input type="text"/> cm	<input type="text"/> kg	<input type="text"/> BMI	<input type="text"/> C	<input type="text"/>	<input type="text"/>	BP Right: <input type="text"/>	BP Left: <input type="text"/>
<input type="text"/> in	<input type="text"/> lbs	<input type="text"/> Body Fat %	<input type="text"/> F				
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Right Vision 20/40 or better
Left Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Hepatomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A
Right Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Splenomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Left Vision 20/40 or better
Left Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Abdominal Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> RUQ	<input type="checkbox"/> RLQ
Right Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection	<input type="checkbox"/> NA	Kidney Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> LUQ
Left Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection	<input type="checkbox"/> NA	Right upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> LLQ
Oral Hygiene	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Right upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia
Thyroid Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Left upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia
Lymph Node Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Right lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia
Heart Murmur (supine)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Left lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished	<input type="checkbox"/> Hyperreflexia
Heart Murmur (upright)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Abnormal Gait	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below	
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular		Spasticity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below	
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear		Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below	
Right Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+		Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below	
Left Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+		Upper Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below	
Radial Pulse Symmetry	<input type="checkbox"/> Yes	<input type="checkbox"/> R>L <input type="checkbox"/> L>R		Lower Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below	
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Upper Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below	
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below	
				Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below	

- Athlete shows no evidence of any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.
- Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

## 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 is **ABLE** to participate in Special Olympics sports without restrictions/limitations.

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions/limitations:

This athlete **MAY NOT** participate in Special Olympics sports at this time and **MUST** be further evaluated by a physician for the following concerns:

<input type="checkbox"/> Concerning Cardiac Exam	<input type="checkbox"/> Acute Infection	<input type="checkbox"/> O <sub>2</sub> Saturation Less than 90% on Room Air
<input type="checkbox"/> Concerning Neurological Exam	<input type="checkbox"/> Stage II Hypertension or Greater	<input type="checkbox"/> Hepatomegaly or Splenomegaly
<input type="checkbox"/> Other, please describe: <input type="text"/>		

## Additional Licensed Examiner's Notes and Recommended Follow-up:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist          | <input type="checkbox"/> Follow up with a neurologist        | <input type="checkbox"/> Follow up with a primary care physician      |
| <input type="checkbox"/> Follow up with a vision specialist     | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist            | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist                |
| <input type="checkbox"/> Other/Exam Notes: <input type="text"/> |  |   |

Name:

Email:

Phone:

Licensed Medical Examiner's Signature:

Date of Exam:

License:

# Athlete Medical Form – MEDICAL REFERRAL FORM

(to be completed by a Medical Professional only if referral is needed)



Athlete's Name:

**This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates follow-up is required. Athlete should bring the previously completed pages to the appointment with the specialist.**

Examiner's Name:

Specialty:

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

In my professional opinion, this athlete **MAY** participate in Special Olympics sports (indicate restrictions or limitations below):

- Yes, without restrictions**       **Yes, but with restrictions**       **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail:

Examiner Phone:

License:

Examiner's Signature

Date

## This Section to be completed by Special Olympics Staff Only, if applicable.

This medical exam was completed at a MedFest Event?       Yes       No

The athlete is a Unified Partner or a Young Athlete Participant?       Unified Partner       Young Athlete