# Athlete Medical Form

**NEW**  **RENEWAL**  **UPDATE**

<table>
<thead>
<tr>
<th>Area</th>
<th>Delegation Code</th>
<th>Delegation Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Physical</td>
<td>MedFest®</td>
<td>Unified Partner <em>(medicals optional)</em></td>
</tr>
</tbody>
</table>

## ATHLETE INFORMATION

- **Name**
  - Last Name
  - First Name
  - Middle Name
  - Nickname

- **Date of Birth**
  - MM/DD/YYYY

- **Gender**
  - Male
  - Female

- **Eye Color**

- **Address**
- **City/State/Zip**

- **Home Phone**
- **Cell Phone**

- **Email**
  - I am my own guardian.  
  - Yes
  - No

- **Employer**
- **Employer's Phone**

- **Employer's Address**
- **City/State/Zip**

- **Sports** the athlete is interested in playing:

## PARENT/GUARDIAN INFORMATION

- **Relationship to Athlete**

- **Name**
  - Last Name
  - First Name

- **Home Phone**
- **Cell Phone**

- **Address**
- **City/State/Zip**

- **Email**

- **Employer**
- **Employer's Phone**

- **Employer's Address**
- **City/State/Zip**

## ATHLETE MEDICAL INFORMATION

- **Primary Care Physician**
  - Physician's Phone

- **Physician's Address**
  - City/State/Zip

- **Other Syndromes**
  - Autism
  - Down Syndrome
  - Fragile X Syndrome
  - Cerebral Palsy
  - Fetal Alcohol Syndrome
  - Other Syndrome *(please specify)*

- **Other Medical/Orthotic Equipment**
  - Dentures
  - Communication Device
  - Wheelchair
  - Brace
  - Removable Prosthetics
  - Crutches or Walker
  - Splint
  - Glasses or Contacts
  - Hearing Aid
  - Pacemaker
  - G-Tube or J-Tube
  - Implanted Device
  - Inhaler

- **Athlete’s Allergies** *(please list)*
  - No Known Allergies
  - Latex
  - Insect Bites or Stings
  - Food
  - Medications

- **Special Dietary Needs**

- **Does the athlete have any religious objections to medical treatment?**
  - Yes
  - No

- **If yes, please complete the religious objections form.**

- **Does the athlete currently have any chronic or acute infection?**
  - Yes
  - No

- **If yes, please describe:**
<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Consciousness</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Dizziness during or after exercise</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Headache during or after exercise</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Chest pain during or after exercise</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Shortness of breath during or after exercise</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Irregular, racing or skipped heat beats</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Congenital Heart Defect</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Heart Valve Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Vision Impairment</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Enlarged Spleen</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Single Kidney</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Osteopenia</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sickle Cell Trait</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Easy Bleeding</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Dislocated Joints</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Concussions</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Asthma</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Urinary Discomfort</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Spina Bifida</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Arthritis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Heat Illness</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Broken Bones</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Any difficulty controlling bowels or bladder</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Numbness or tingling in legs, arms, hands or feet</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Weakness in legs, arms, hands or feet</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Head Tilt</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Spasticity</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Paralysis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Epilepsy or any type of seizure disorder</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Seizure during the past year</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Self-injurious behavior during the past year</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Depression</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Anxiety</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Please describe any additional mental health concerns:</td>
<td></td>
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</tr>
</tbody>
</table>
Athlete Medical Form

MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS (includes inhalers, birth control or hormone therapy)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Times per Day</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Is the athlete able to administer his/her own medications? ☐ No ☐ Yes

If female, date of athlete’s last menstrual period:

PLEASE READ BEFORE SIGNING

It is understood and agreed that: if the examiner is provided free of charge, it is not intended to be a thorough or comprehensive examination. No physician-patient relationship is to arise out of the examination. The doctor, nurse or other person involved in the examination is under no obligation to provide a diagnosis, treatment, advice, consultation or any follow-up care whatsoever under any circumstances. The fact that any person is cleared or authorized to participate in any sport or other activity does not mean and is not to be interpreted as the opinion of the doctor or nurse that the person examined is healthy, in need of no care, or can participate in any sport or other activity without serious medical risks. Any claim against the doctor, nurse or other person involved in the examination will be submitted to binding arbitration pursuant to the rules and procedures of the American Arbitration Association. The person examined and any person who signs on his or her behalf promises to indemnify the doctor or nurse from any and all damages, claims, or losses, including injury or death that allegedly arise out of or are in any way related to the examination.

Participation: I hereby give my permission for the participant named above to participate in any Special Olympics activity or event of any kind. I understand that participation at local or area competition does not guarantee advancement to State or World Games. Athletes must be registered using this release form prior to any athlete training.

Medical: I represent and warrant to you that the athlete is physically and mentally able to participate in Special Olympics Texas.

Disclaimer: On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release the physicians, organizers, officers, directors, agents or employees of Special Olympics Texas from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or the athlete.

Hospitalization: If I am not personally present at the event in which the athlete is to compete so as to be consulted in case of emergency, you are authorized on my behalf and at my account to take such measure and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete.

Media: In permitting the athlete to participate, I am specifically granting permission to you to use the name, likeness, voice, words, and biographical information of the athlete in television, radio, films, newspapers, magazines, web pages and other media, and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of Special Olympics Texas and in appealing for funds to support such activities.

SOTX Housing Policy: For any overnight trip, a gender-specific athlete to chaperone ratio of 4 to 1 is required (see SIG section N for specific breakdown). No athletes or volunteers of opposite genders may room together. The only exceptions are: if the athletes/volunteers are married; or if a family member of the opposite gender is chaperoning. Unified Partners under the age of 17 should be included in the ratio as in need of a chaperone.

ATHLETE OR PARENT/GUARDIAN SIGN AND DATE

Printed Name

Check One: ☐ Parent ☐ Guardian ☐ Athlete (if over the age of 18)

Signature           Date
Athlete Physical

TO BE COMPLETED BY MEDICAL EXAMINER ONLY

Athlete Last Name

Athlete First Name

<table>
<thead>
<tr>
<th>ATHLETE MEDICAL PHYSICAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height _____ cm _____ in</td>
</tr>
<tr>
<td>Temp _____ °C _____ °F</td>
</tr>
</tbody>
</table>

Blood Pressure: BP Right

Right Vision: 20/40 or better?  o No  o Yes  o N/A

Blood Pressure: BP Left

Left Vision: 20/40 or better?  o No  o Yes  o N/A

- This athlete may participate in Special Olympics sports at this time and must be evaluated by a physician for the following concerns:
  - Concerning Cardiac Exam
  - Concerning Neurological Exam
  - Other, please describe:

Additional Licensed Examiner Notes:
- Follow up with a cardiologist
- Follow up with a vision specialist
- Follow up with a podiatrist
- Other, please describe:

Recommended Actions:
- Follow up with a neurologist
- Follow up with a hearing specialist
- Follow up with a physical therapist
- Follow up with a primary care physician
- Follow up with a dentist or dental hygienist
- Follow up with a nutritionist

MEDICAL EXAMINER SIGN AND DATE

Signature of Licensed Physician, Physician’s Assistant licensed by State Board of Physicians Assistant Examiners, or Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.

Date of Exam

Printed Name

Email

Phone ( ) License

- o Athlete does not have any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.
- o Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and therefore must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

Recommended Actions:
- Follow up with a podiatrist
- Follow up with a vision specialist
- Follow up with a cardiologist
- Follow up with a hearing specialist
- Follow up with a physical therapist
- Follow up with a nutritionist

- 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 next page: Special Olympics Further Medical Evaluation Form, in order to provide the athlete with medical clearance.

- YES - This athlete is able to participate in Special Olympics sports. (Use Additional Licensed Examiner’s Notes for any restrictions or limitations).
- NO - This athlete may not participate in Special Olympics sports at this time and must be evaluated by a physician for the following concerns:
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- Follow up with a dentist or dental hygienist
- Follow up with a nutritionist

- 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 next page: Special Olympics Further Medical Evaluation Form, in order to provide the athlete with medical clearance.

- YES - This athlete is able to participate in Special Olympics sports. (Use Additional Licensed Examiner’s Notes for any restrictions or limitations).
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- Follow up with a dentist or dental hygienist
- Follow up with a nutritionist

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- Follow up with a nutritionist
<table>
<thead>
<tr>
<th>Athlete Last Name</th>
<th>Athlete First Name</th>
</tr>
</thead>
</table>

### FURTHER MEDICAL EVALUATION

**Examiner’s Name** | **Specialty**
---|---

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

- YES  - NO  

In my professional opinion, this athlete may participate in Special Olympics sports (see below for restrictions or limitations).

**Additional Licensed Examiner Notes:**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Email</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone (  )</th>
<th>License</th>
</tr>
</thead>
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**Examiner’s Name** | **Specialty**
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<th>Phone (  )</th>
<th>License</th>
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### FURTHER MEDICAL EVALUATION

**Examiner’s Name** | **Specialty**
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