

Athlete Medical Form-Physical Examination

(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 ₂ 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 <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 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	Left Vision <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A 20/40 or better
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 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 <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ	
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"/> Right <input type="checkbox"/> Left	
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"/> Diminished <input type="checkbox"/> Hyperreflexia	
Oral Hygiene	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Left 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		Right lower 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		Left 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	Abnormal Gait	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below	
Heart Murmur (upright)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Spasticity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below	
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular		Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below	
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear		Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, 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+		Upper Extremity 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+		Lower 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		Upper Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below	
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below	
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		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 ₂ 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 |

Other/Exam Notes:

Name:

Email:

Licensed Medical Examiner's Signature

Date of Exam

Phone:

License:

Athlete Medical Form-Health History



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

County
Organization

ATHLETE INFORMATION

PARENT GUARDIAN INFORMATION (if not own guardian)

First Name Middle Name:
Last Name
Date of birth month/day/year Female Male

Name:
Phone: Cell:
E-mail:

Address (Street)
Address (City, State, Zip):
Phone: Cell:
E-mail:
Eye color: Ethnicity: (voluntary)
Employer:

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):

I am my own guardian. Yes No

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.*

Does the athlete have (check any that apply):

List any sports the athlete wishes to play:

- 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):

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

- Latex
- No Known Allergies
- Medications:
- Insect Bites or Stings:
- Food:

No Yes *If yes, please describe:*

List any special dietary needs:

Does the athlete use (check any that apply):

List all past surgeries:

- 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

Does the athlete currently have any chronic or acute infection?

FAMILY HISTORY

No Yes *If yes, please describe:*

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

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

Has the athlete ever had an abnormal Electrocardiogram (EKG) or an abnormal Echocardiogram (Echo)? *If yes, select below and describe*

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

Yes, had abnormal EKG Yes, had abnormal Echo

Athlete Medical Form-Health History

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

Special Olympics
Ohio



Athlete's name

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

List any other ongoing or past medical conditions:

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:

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 athlete, list date of last menstrual period:**

Athlete signature (if own guardian)

Date

Guardian Signature (Only needed if not own guardian)
Relationship to Athlete

Date

SOCIAL MEDIA RELEASE FORM

This Social Media Release ("Release") is executed on _____, by _____ ("Releasor"), who acknowledges and agrees to the terms below:

1. The Releasor grants permission to Upper Arlington Special Olympics ("Releasee") to use their image, voice, or likeness in photographs, audio recordings, or video recordings on Releasee's website and social media accounts, including, but not limited to, Facebook, Instagram, TikTok, and X (Twitter), without acknowledgment or recognition given to the Releasor.
2. The Releasor grants the Releasee creative permission to alter the photographs, provided that the photographs are not altered in an explicit manner or used to maliciously represent the Releasor or their associates.
3. The Releasor understands that they will not receive any monetary compensation from the Releasee for the permissions granted herein and hereby waives any right of inspection or approval of the photos or recordings prior to the Releasee posting on their social media accounts.
4. The Releasor acknowledges that any third party (including any agency, client, publication, or other organization or institution) may distribute the photographs and recordings on their social media accounts for the purposes of publicity and promotion of the Releasee.
5. In giving this consent, the Releasor releases the Releasee from liability for any violation of any personal or proprietary right the Releasor may have in connection with all third parties' use of the images on social media.
6. The Releasor certifies that they are 18 years of age or older. If the Releasor is under the age of 18, their parent or guardian must sign this Release.

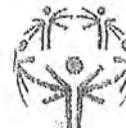
In witness whereof, the Releasor executes this Release by signing below.

Releasor Signature: Date: _____

Print Name: _____

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.** If I am unable, or my guardian is unavailable, to make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I check 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 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 athletes (identifying information removed if shared publically); and
 - Protect health and safety, respond to government requests, and report information required by law.

I can ask to see and change my information.

I understand Special Olympics is a global organization with headquarters in the United States of America. I consent to Special Olympics processing my information in countries with different privacy and data security laws, including the United States of America.

ATHLETE NAME: _____

ATHLETE SIGNATURE (required for athlete over 18 years old with capacity to sign legal documents)

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 for athlete under 18 years old or lacking 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: _____