



# ATHLETE MEDICAL FORM

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

Retain a copy for County/School files. Use pen and print legibly.

## SECTION A: GENERAL INFORMATION (REQUIRED)

ATHLETE NAME: \_\_\_\_\_  
 COUNTY PROGRAM: \_\_\_\_\_

GENDER:  MALE  FEMALE  
 DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

### ATHLETE INFORMATION

ADDRESS: \_\_\_\_\_  
 CITY/STATE/ZIP: \_\_\_\_\_  
 HOME PHONE: (\_\_\_\_) \_\_\_\_\_  
 CELL PHONE: (\_\_\_\_) \_\_\_\_\_  
 EMAIL: \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

HEALTH COMPANY: \_\_\_\_\_  
 POLICY #: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

NAME: \_\_\_\_\_  
 CELL PHONE: (\_\_\_\_) \_\_\_\_\_

## SECTION B: MEDICAL HISTORY

*A physical examination performed by a licensed examiner is required every three (3) years for Athletes with YES in items 1-6.*

*An exam is required the first time NEW is checked in items 7-13.*

	YES	NO	NEW		YES	NO
1. Heart Disease/Heart Defect/High Blood Pressure				14. Uses a wheelchair		
2. Chest Pain or Fainting Spells				15. Allergy to the following (list specific)		
3. Seizures/Epilepsy				Medicine _____		
4. Diabetes				Foods _____		
5. Down Syndrome				Insect Sting/Bite _____		
Have cervical spine (neck bone) x-rays been done				16. Special Diet		
Atlantoaxial Instability				17. Exercise induced wheezing		
6. Parent/Sibling (under 40) died of heart disease				18. Tendency to bleed easily		
7. Absence of vision/blind in one eye				19. Emotional/Psychiatric/Behavioral Problems		
8. Absence of one kidney or testicle				20. Serious Bone or Joint Disorder		
9. Concussion or serious head injury				21. Sickle Cell Trait or Disease		
10. Major surgery or serious illness				22. Hearing Aid/Hearing Loss		
11. Heat Stroke/exhaustion				23. Contact Lenses/Eyeglasses		
12: Other problem that would interfere with sports participation				24. Dentures/False Teeth		
List: _____				25. Immunizations (shots) are up-to-date		
13. Impaired Motor Ability				26. Date of last Tetanus Shot ____/____/____		

Comments: \_\_\_\_\_

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

Person completing form (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)

**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 C: 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, snowboarding, flag Football team competition, and 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: (\_\_\_\_) \_\_\_\_\_