FORM

Special Olympics
Indiana
Be a fan...

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

Athlete Name _____ M F _____/_____/_____

Address _____ Home Phone _____

_____

Parent/Guardian Name _____ Work Phone _____

Address (if different than athlete) _____ Home Phone _____

Emergency Contact (if other than parent/guardian) _____ Home Phone _____

Health/Accident Company _____ Policy # _____

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

► **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.**

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

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: _____