

# Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)



Medical Form Valid for 3 years from date of medical professional's signature

Region \_\_\_\_\_ Primary Agency Name \_\_\_\_\_ Secondary Agency Name \_\_\_\_\_

Name of person completing form: \_\_\_\_\_ Relationship to Athlete \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_ Date Completed \_\_\_\_\_

If individual is a new athlete, has turned 18 since their last Medical Form submission or has a change in their guardianship status then a Special Olympics Illinois Consent Form must be submitted with the Medical Form.

## ATHLETE INFORMATION

Athlete Last Name: \_\_\_\_\_ Athlete First Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Athlete Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Athlete Gender Identity: Female Male Other

Athlete Ethnicity/Race:

Asian	American Indian/Alaskan Native	Black/African American
Hispanic/Latino	Native Hawaiian/Other Pacific Islander	W White
Two or More Races	Other	Prefer Not to Answer

If a new athlete, has athlete ever been convicted or charged with a criminal offense other than minor traffic violations? No Yes

If a currently registered athlete, in the past 3 years has athlete been convicted or charged with a criminal offense other than minor traffic violations? No Yes *If the answer to either question is Yes, Special Olympics Illinois may require additional information from the athlete or responsible parent/guardian.*

Athlete Mailing Address: Street \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Athlete Email Address: \_\_\_\_\_ Athlete Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Athlete Employer (if applicable): \_\_\_\_\_

Name of Athlete's Primary Physician / Health Provider: \_\_\_\_\_

## PARENT / GUARDIAN INFORMATION

Athlete is or is not their own guardian (Please mark appropriate box)

The following information is for the Parent or Guardian of the athlete listed above.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Mailing Address (if different than athlete's):

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Contact Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION (Must list at least one emergency contact)

Emergency Contact Person #1: Name \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Person #2: Name \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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(To be completed by the athlete or parent/guardian/caregiver and brought to exam)



Athlete's First and Last Name: \_\_\_\_\_

## DIAGNOSED SYNDROMES (check all that apply)

Autism      Down Syndrome      Fragile X Syndrome      Cerebral Palsy      Fetal Alcohol Syndrome      Other: \_\_\_\_\_

## HEART HEALTH & HISTORY (check all that apply)

Congenital Heart Defect	No	Yes	Treated in past 12 months	Heart Murmur	No	Yes	Treated in past 12 months
Heart Attack	No	Yes	Treated in past 12 months	Heart Illness	No	Yes	Treated in past 12 months
High Blood Pressure	No	Yes	Treated in past 12 months	Chest pain during or after exercise	No	Yes	Treated in past 12 months
Cardiomyopathy	No	Yes	Treated in past 12 months	Ever had abnormal EKG	No	Yes	Treated in past 12 months
Pacemaker	No	Yes	Treated in past 12 months	Ever had abnormal Echo	No	Yes	Treated in past 12 months
Heart Valve Disease	No	Yes	Treated in past 12 months	Other: _____	No	Yes	Treated in past 12 months

## HEAD INJURY HISTORY (check all that apply)

Concussion(s)      No      Yes      Treated in past 12 months  
Traumatic Brain Injury (TBI)      No      Yes      Treated in past 12 months      Other: \_\_\_\_\_      No      Yes      Treated in past 12 months

## VISION AND/OR HEARING ISSUES (check all that apply)

Legally Blind      Deaf      Glasses or Contacts  
Vision Impaired      Hearing Impaired      Hearing Aids

## ALLERGIES & DIETARY RESTRICTIONS (check all that apply & explain when indicated)

Latex      Insect Bites or Stings: \_\_\_\_\_  
Food: \_\_\_\_\_      Medications: \_\_\_\_\_      Other: \_\_\_\_\_

## PULMONARY HEALTH & HISTORY (check all that apply)

Asthma	No	Yes	Treated in past 12 months	Sleep Apnea (C-PAP Machine)	No	Yes	Treated in past 12 months
COPD	No	Yes	Treated in past 12 months	Other: _____	No	Yes	Treated in past 12 months
Uses an Inhaler	No	Yes	Treated in past 12 months				

## MENTAL HEALTH (check all that apply)

Self-injurious behavior during the past year      No      Yes      Anxiety (diagnosed)      No      Yes      Depression (diagnosed)      No      Yes  
Aggressive behavior during the past year      No      Yes      Describe any additional mental health concerns: \_\_\_\_\_

## OTHER MEDICAL CONDITIONS (check all that apply)

Stroke/TIA	No	Yes	Treated in past 12 months	Arthritis	No	Yes	Treated in past 12 months
Diabetes	No	Yes	Treated in past 12 months	Dislocated Joints	No	Yes	Treated in past 12 months
Heat Exhaustion	No	Yes	Treated in past 12 months	Syncope	No	Yes	Treated in past 12 months
Heat Stroke	No	Yes	Treated in past 12 months	Hepatitis	No	Yes	Treated in past 12 months
Colostomy	No	Yes	Treated in past 12 months	Sickle Cell Trait/Disease	No	Yes	Treated in past 12 months
G-Tube or J-Tube	No	Yes	Treated in past 12 months	Seizure Disorder	No	Yes	Treated in past 12 months
Epilepsy	No	Yes	Treated in past 12 months	Other: _____	No	Yes	Treated in past 12 months

Has athlete had a Tetanus vaccine in past 7 years?      No      Yes      Date of Shot \_\_\_\_\_

Is athlete pregnant?      No      Yes      Expected Due Date \_\_\_\_\_ Month \_\_\_\_\_ Year

## NEUROLOGICAL SYMPTOMS FOR SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (check all that apply)

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 MEDICATION, VITAMINS OR DIETARY/HERBAL/NUTRITIONAL SUPPLEMENTS (includes inhalers, birth control, hormone therapy)

Medication/Vitamin/Supplement Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Times Per Day: \_\_\_\_\_  
Medication/Vitamin/Supplement Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Times Per Day: \_\_\_\_\_  
Medication/Vitamin/Supplement Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Times Per Day: \_\_\_\_\_

Is the athlete able to administer their own medications?      No      Yes

# Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)



Athlete's First and Last Name: \_\_\_\_\_

## MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

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

### SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)

Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.

OR

Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

### ATHLETE CLEARANCE TO PARTICIPATE (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 needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

This athlete is **ABLE** to participate in Special Olympics sports without restrictions.

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe → \_\_\_\_\_

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

Concerning Cardiac Exam

Acute Infection

O<sub>2</sub> Saturation Less than 90% on Room Air

Concerning Neurological Exam

Stage II Hypertension or Greater

Hepatomegaly or Splenomegaly

Other, please describe:

### Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

Follow up with a cardiologist

Follow up with a neurologist

Follow up with a primary care physician

Follow up with a vision specialist

Follow up with a hearing specialist

Follow up with a dentist or dental hygienist

Follow up with a podiatrist

Follow up with a physical therapist

Follow up with a nutritionist

Other/Exam Notes:

Signature of Licensed Medical Examiner	Exam Date	Name:
		E-mail:
		Phone: - -

# Athlete Medical Form – MEDICAL REFERRAL FORM

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



Athlete's First and Last Name: \_\_\_\_\_

**This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.**

**Athlete should bring the previously completed pages to the appointment with the specialist.**

Examiner's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

Concerning Cardiac Exam      Acute Infection      O<sub>2</sub> Saturation Less than 90% on Room Air

Concerning Neurological Exam      Stage II Hypertension or Greater      Hepatomegaly or Splenomegaly

Other, please describe:

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

**Yes**

**Yes, but with restrictions (*list below*)**

**No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: \_\_\_\_\_

Examiner Phone: \_\_\_\_\_

**Examiner's Signature**

**Date**

## SPECIAL OLYMPICS ILLINOIS ATHLETE CONSENT, WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION FORM

Athlete Name: Last \_\_\_\_\_ First \_\_\_\_\_

Athlete Date of Birth \_\_\_\_MM \_\_\_\_DD \_\_\_\_YY

Region \_\_\_\_\_ Agency Name \_\_\_\_\_

Are you a new athlete to Special Olympics Illinois or re-registering?

New Athlete  Re-Registering

Special Olympics Illinois - hereafter referred to as SOILL.

An athlete must also have a valid Medical Form on file with SOILL to be eligible to participate.

If individual is a new athlete, has turned 18 since their last Medical Form submission or has a change in their guardianship status then an updated SOILL Consent Form must be submitted with the Medical Form.

I, on my own behalf or as the undersigned parent and/or legal guardian of the above named applicant (hereafter referred to as the "Entrant") do hereby:

- Request permission for the Entrant to participate in SOILL programs.
- Represent and warrant to you that Entrant is physically and mentally able to participate in SOILL sports training and competition.
- Acknowledge that SOILL will screen all entrants using the Sex Offender Public Registry and understand that entrants listed on the Registry will be denied participation. I affirm that this Entrant has never been on said Registry or, if Entrant was listed on said Registry but has since been removed, I will contact SOILL for instructions before submitting this form.
- Acknowledge that Entrants charged or convicted of a criminal offense are subject to SOILL's Eligibility Policy, and agree that SOILL may conduct a criminal background check in appropriate circumstances. Entrant further acknowledges that Entrant understands and will follow SOILL's Eligibility Policy.
- Acknowledge that Entrant understands and will execute and follow the Athlete Partner Code of Conduct.
- Acknowledge that Entrant understands and will execute and follow the COVID Code of Conduct.
- Acknowledge that Entrant understands that participation includes possible exposure to an illness from infectious and/or communicable diseases including but not limited to MRSA, influenza and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and, Entrant willingly agrees to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, Entrant observes any unusual or significant hazard during presence or participation, Entrant will remove them selves from participation and bring such to the attention to the nearest official immediately.
- Acknowledge that Entrant understands there is a risk of injury and understands the risk of Entrant continuing to play sports with or after a concussion or other injury. Entrant may have to get medical care if they have a suspected concussion or other injury. Entrant may have to wait 7 days or more and get permission from a doctor before resuming sports activities.
- In permitting the Entrant to participate, I am specifically granting permission to SOILL and Special Olympics Inc. to use the likeness photo, video, name, voice, words and biographical information in television, radio, films, newspapers, magazines, social media and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of SOILL and Special Olympics Inc. in appealing for funds to support such activities.
- Consent for Entrant to participate in the SOILL Healthy Athlete Program that provides individual screening assessments of health status and health care needs. Entrant has no obligation to participate and I understand the Entrant should seek his/her/their own medical advice and assistance and SOILL is not responsible for the Entrant's health.
- For some events, Entrant may stay in a hotel, university type housing or someone's home. If I have questions I will ask.
- If I am unable, or my parent/guardian is unavailable, to consent or make medical decisions in an emergency, I authorize SOILL to seek medical care on my behalf.
- I understand that SOILL will be collecting Entrant's personal information as part of participation, including name, image, address, telephone number, health information and other provided personally identifying and health related information. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics Inc.

Athlete Name: Last \_\_\_\_\_ First \_\_\_\_\_

Privacy Policy at [www.SpecialOlympics.org/Privacy-Policy](http://www.SpecialOlympics.org/Privacy-Policy) I further agree and consent to SOILL:

- Using Entrant personal information in order to: make sure Entrant is eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); analyze data for the purpose of improving programming and identifying and responding to the needs of SOILL participants; perform computer operations, quality assurance, testing and other related activities; and provide event-related services.
- Using Entrant contact information for communicating with me about SOILL.
- Sharing information with medical professionals in an emergency or for injury treatment.

Entrants, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HERBY FREELY AND VOLUNTARILY ASSUME ALL RISK, WAIVE AND RELEASE FROM LIABILITY, AGREE TO INDEMNIFY AND HOLD HARMLESS, Special Olympics Illinois, it's officers, officials, agents and/or employees, other participants, coaches, sponsoring agencies, sponsors, advertisers and if applicable, owners and lessors of the venue/premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I, THE UNDERSIGNED ADULT ENTRANT, have read and fully understand the provisions of the ATHLETE CONSENT, WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION FORM and/or have had them explained to me. I hereby agree that I will be bound thereby and I shall defend SOILL and hold it harmless from disaffirmation thereof.

**Signature of Entrant** \_\_\_\_\_

\_\_\_\_\_ Athlete is own guardian

Witness \_\_\_\_\_ Date \_\_\_\_\_

**OR**

FOR ENTRANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION), OR THOSE WHO LACK LEGAL CAPACITY TO SIGN DOCUMENTS

This is to certify that I, as parent, guardian, and/or individual with legal responsibility for this Entrant, have read and explained the provisions in this ATHLETE CONSENT, WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION FORM to said Entrant including the risks of presence and participation, as well as their personal responsibilities to adhere to the rules and regulations promulgated by SOILL. Furthermore, said Entrant understands and accepts these risks and responsibilities. I, for myself, spouse (if applicable), and Entrant do hereby consent and agree that said Entrant freely and voluntarily assumes all risk, and that we waive and release from liability, indemnify and hold harmless the above referenced RELEASEES for any and all liabilities incident to said Entrant's presence or participation in SOILL sports, training, competition and/or any other SOILL group activities as provided above, EVEN IF ARISING FROM THE RELEASEE'S NEGLIGENCE, OR OTHERWISE to the fullest extent provided by law.

Parent/Guardian/legally responsible individual's signature (required for Entrant who is a minor (younger than age 18) or otherwise lacks legal capacity to sign document).

**Printed Name of parent/guardian/legally responsible individual:** \_\_\_\_\_

**Signature of parent/guardian/legally responsible individual:** \_\_\_\_\_

Date: \_\_\_\_\_

Email address of Parent/Guardian/legally responsible individual: \_\_\_\_\_

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**Signature of Entrant** \_\_\_\_\_

\_\_\_\_\_ Athlete is own guardian

Witness \_\_\_\_\_ Date \_\_\_\_\_

**OR**

FOR ENTRANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION), OR THOSE WHO LACK LEGAL CAPACITY TO SIGN DOCUMENTS

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Parent/Guardian/legally responsible individual's signature (required for Entrant who is a minor (younger than age 18) or otherwise lacks legal capacity to sign document).

**Printed Name of parent/guardian/legally responsible individual:** \_\_\_\_\_

**Signature of parent/guardian/legally responsible individual:** \_\_\_\_\_

Date: \_\_\_\_\_

Email address of Parent/Guardian/legally responsible individual: \_\_\_\_\_