Special Olympics Indiana

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: _____ SOCIAL SECURITY #: _____-_____-_____

COUNTY PROGRAM: _____ DATE OF BIRTH: _____/_____/_____
MONTH DAY YEAR

GENDER: ☐ MALE ☐ FEMALE

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
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: _____			
13. Impaired Motor Ability	☐	☐	☐

	YES	NO
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 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: (_____)_____