FORM A

ATHLETE REGISTRATION FORM

Special Olympics South Dakota

State Special Olympics Program: Special Olympics South Dakota

Are you a new athlete to Special Olympics or Re-Registering? ☐ New Athlete ☐ Re-Registering

ATHLETE INFORMATION		
First Name:	**Middle Name:**	
Last Name:	**Preferred Name:**	
Date of Birth (mm/dd/yyyy):	☐ Female ☐ Male	
Race/Ethnicity (Optional): ☐ American Indian/Alaskan Native ☐ Asian ☐ Two or More Races ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Hispanic or Latino (specific origin group:_____)		
Language(s) Spoken in Athlete's Home (Optional): Check all that apply ☐ English ☐ Spanish ☐ Other (please List):		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? ☐ Yes ☐ No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
☐ **Same Contact Info as Athlete**		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
EMERGENCY CONTACT INFORMATION		
☐ **Same as Parent/Guardian**		
Name:		
Phone:	**Relationship:**	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

FORM B

ATHLETE RELEASE FORM

Special Olympics South Dakota

I agree to the following:
Ability to Participate. I am physically able to take part in Special Olympics activities.

Likeness Release. I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.

Risk of Concussion and Other Injury. I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

Emergency Care. If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

☐ I have a religious or other objection to receiving medical treatment. (Not common.)
☐ I do not consent to blood transfusions. (Not common.)

(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

Overnight Stay. For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.

Health Programs. If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.

Personal Information. I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").

- I agree and consent to Special Olympics:
  - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
  - using my personal information and creating a profile of me for communications and marketing purposes, including direct digital marketing through email, SMS, social media, and other channels.
  - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
- I understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
- I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
- Sharing of Personal Information. Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy_Policy.aspx.

Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below.

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use my likeness, photo, video, name, voice, and words ("my likeness") to acknowledge the sponsors' and partners' support for Special Olympics.
- Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
- I understand I will not be compensated for the use of my Likeness.

Athlete Name:	**E-mail:**
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks 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:**

COMMUNITY REINVESTMENT ACT

INCOME CERTIFICATION INFORMATION

Special Olympics South Dakota

The Community Reinvestment Act holds financial institutions accountable to help meet the needs of their communities, including low- and moderate-income communities, through loans, investments and services. One of the ways financial institutions can meet these needs is through donations and volunteerism to agencies that provide services to low- and moderate-income individuals.

The information below is being requested so that Special Olympics South Dakota can qualify as a CRA eligible recipient of donations and volunteer services. By providing this information, Special Olympics South Dakota can qualify for additional funding sources.

Special Olympics South Dakota will treat the information you provide as confidential. The summary of information that is provided to financial institutions by Special Olympics South Dakota will not disclose the details you furnish below.

Do you currently utilize or qualify for any of the following services?

☐Yes ☐No Medicaid

☐Yes ☐No Food Stamps

☐Yes ☐No Rental Assistance (State or Federal Rental Assistance Program)

☐Yes ☐No Free or Reduced Lunch Program

If you answered YES to **any** of the questions above, you DO NOT need to provide the information requested below.

Is your annual household Income less than $49,360?* ☐YES ☐NO (if participant is a dependent, use the parent or guardian's income)

***Annual Household Income** includes pre-tax income from all household members for employment, self-employment, child support, Social Security, BIA General Assistance. Subtract $50 per month of child support received and all child support paid.

Number of people in your household: _____

Athlete Name: _____ Date: _____

Athlete Medical Form – **HEALTH HISTORY**

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

Special Olympics

Athlete First & Last Name:_____ **Preferred Name:**_____

Athlete Date of Birth (mm/dd/yyyy):_____ ☐ Female ☐ Male

STATE PROGRAM:_____ **E-mail:**_____

ASSOCIATED CONDITIONS - **Does the athlete have** *(check any that apply)*:

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ Other Syndrome, please specify:_____

ALLERGIES & DIETARY RESTRICTIONS

☐ No Known Allergies
☐ Latex
☐ Medications:_____
☐ Insect Bites or Stings:_____
☐ Food:_____

ASSISTIVE DEVICES - **Does the athlete use** *(check any that apply)*:

☐ 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

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?
☐ No ☐ Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?
☐ No ☐ Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*
☐ Yes, had abnormal EKG
☐ Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

*If yes, list seizure type:*_____

If yes, had seizure during the past year? ☐ No ☐ Yes

MENTAL HEALTH

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:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes
Has any family member or relative died while exercising? ☐ No ☐ Yes
List all medical conditions that run in the athlete's family:

Athlete Medical Form – **HEALTH HISTORY**

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

Athlete's First and Last Name:_____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Stroke/TIA	☐ No	☐ Yes
Dizziness during or after exercise	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	Concussions	☐ No	☐ Yes
Headache during or after exercise	☐ No	☐ Yes	Vision Impairment	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Chest pain during or after exercise	☐ No	☐ Yes	Hearing Impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Shortness of breath during or after exercise	☐ No	☐ Yes	Enlarged Spleen	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Irregular, racing or skipped heart beats	☐ No	☐ Yes	Single Kidney	☐ No	☐ Yes	Urinary Discomfort	☐ No	☐ Yes
Congenital Heart Defect	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes	Spina Bifida	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes	Osteopenia	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Easy Bleeding	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ Yes
Endocarditis	☐ No	☐ Yes						

If female athlete, list date of last menstrual period:_____

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above)*:

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

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

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**

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_2Sat	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	
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA
Oral Hygiene	☐ Good	☐ Fair	☐ Poor	
Thyroid Enlargement	☐ No	☐ Yes		
Lymph Node Enlargement	☐ No	☐ Yes		
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	
Heart Rhythm	☐ Regular	☐ Irregular		
Lungs	☐ Clear	☐ Not clear		
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R	
Cyanosis	☐ No	☐ Yes, describe		
Clubbing	☐ No	☐ Yes, describe		

Bowel Sounds	☐ Yes	☐ No			
Hepatomegaly	☐ No	☐ Yes			
Splenomegaly	☐ No	☐ Yes			
Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ	☐ LLQ
Kidney Tenderness	☐ No	☐ Right	☐ Left		
Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Abnormal Gait	☐ No	☐ Yes, describe below			
Spasticity	☐ No	☐ Yes, describe below			
Tremor	☐ No	☐ Yes, describe below			
Neck & Back Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Mobility	☐ Full	☐ Not full, describe below			
Lower Extremity Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Strength	☐ Full	☐ Not full, describe below			
Lower Extremity Strength	☐ Full	☐ Not full, describe below			
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_2 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:

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

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_2 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: _____

License: _____

Examiner's Signature	**Date**

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? ☐ Yes ☐ No

The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete

MEDICAL FORM INSTRUCTIONS

The Special Olympics Medical Form is divided into two sections:

1. The health history (the first two pages) asks for information about the athlete's medical history. This section must be completed prior to the athlete seeing a physician for a pre-participation sports physical and should be filled out by the person (or people) who can give the most complete and accurate account of the athlete's medical history. That might include the athlete themselves, the parent or guardian, or a caregiver or group home aide.

2. The physical exam (page 3) should be completed and signed by a physician or other licensed healthcare personnel such as nurse practitioners or physician assistants.

It is required that all athletes new to the Special Olympics complete a medical form prior to participation. Furthermore it is recommended that all Special Olympics athletes update their medical form completely every three years, if not more frequently.

NOTE: There is a separate registration form and a release form that should accompany the medical form for any new or re-registering Special Olympics athlete.

Health History Instructions (Pages 1-2)
(To be Completed by the Athlete, Parent or Guardian or Caregiver)

Health History (Page 1)

1) **Athlete First and Last Name**
2) **Preferred Name –** If the athlete has a nickname or a middle name they preferred to be called, list that here.
3) **Athlete Date of Birth** – Enter Month/Day/Year for US Athletes (or Day/Month/Year for athletes outside the US).
4) **Gender** – Check whether the athlete is Male or Female
5) **STATE/COUNTRY** – This should be the Special Olympics Program (the country or state) you will compete at.
6) **Email Address** – Enter the athlete's email address or a contact email for the parent/guardian/caregiver.
7) **Associated Conditions** – State if the athlete has: autism, cerebral palsy, Down syndrome, Fragile X syndrome and/or Fetal Alcohol syndrome. If the athlete has any other syndrome or condition that caused the athlete's intellectual disability, please list it in the box marked "other syndrome".

8) **Allergies** – Specify any food, medication, insect or latex allergies that the athlete may have. If the athlete has no allergies, mark "No Known Allergies".

9) **Special Dietary Needs** – List any dietary needs that the athlete has, for example: gluten free diet, vegetarian, vegan, lactose free, peanut free, or any religious diet preferences

10) **Assistive Devices** – Specify if the athlete uses any assistive devices such as:
    a. Brace - a device or wrap to support your back, knee, ankle, wrist, elbow, etc.
    b. Colostomy bag
    c. communication device
    d. C-PAP machine - a machine used in the treatment of sleep apnea
    e. crutches or walker
    f. dentures
    g. glasses or contacts
    h. G-tube or J-tube
    i. hearing aid
    j. implanted device - such as a pump, stimulator, shunt, port, monitor or other foreign body
    k. inhaler
    l. pacemaker
    m. removable prosthetic
    n. wheel chair

11) **Sports Participation** – List any sports that the athlete is interested in playing with Special Olympics

12) **Previous Limitations** – Note if any doctor has ever prohibited the athlete from participating in sports for any medical reason. If so, specify the reason.

13) **Surgical History** – List any past surgeries that the athlete has had and why the athlete had the surgery. It is especially important to note and surgeries involving the heart, lungs, brain or spine

14) Cardiac History-
   a. Specify if the athlete has ever had a close relative (parent, grandparent, aunt, uncle, brother, sister or cousin) die from heart problems before the age of 50 or while they were exercising
   b. Specify if the athlete has ever had an abnormal electrocardiogram (EKG, ECG) or echocardiogram (echo). If yes, please describe what cardiac abnormality was found

15) **Active Infection** – If the athlete has ANY acute infection (including minor infections such as a cold or flu), or if the athlete has any chronic bacterial or viral infection, please describe the infection and any treatment

16) **Tetanus Vaccine** – Specify if the athlete has had a tetanus (sometimes called a DTaP or DTP vaccine) within the past 7 years. If not, the athlete may be required to obtain a tetanus vaccine prior to participation, specifically for World Games

17) **Epilepsy/Seizures** – Check if the athlete has a seizure disorder and, if so, what kind of seizures (if known)
   a. If the athlete does have a history of seizures or epilepsy, check whether the athlete has had one or more seizures within the past year

18) **Mental Health**

self-injurious behaviors	This might include hitting or hurting themselves
aggressive behaviors	This might include hitting or hurting others.
Depression	Check if the athlete has been diagnosed as depressed by a doctor.
Anxiety	Check if the athlete has been diagnosed as having anxiety by a doctor.
Describe any additional mental health concerns	List any other mental health concerns such as AD/HD, schizophrenia, bipolar, psychosis, etc., that the athlete has currently or has had in the past.

19) **Family History** – List any conditions that run in the athlete's family. It is especially important to note any genetic, neurological (brain) or cardiac (heart) conditions

Health History (Page 2)

20) **Specific Medical Conditions** – Check all medical conditions that the athlete currently has or has had in the past

Item	**Definition**
Loss of Consciousness	n/a
Dizziness during or after exercise	n/a
Headache during or after exercise	n/a
Chest pain during or after exercise	n/a
Shortness of breath during or after exercise	n/a
Irregular, racing or skipped heart beats	n/a
Congenital Heart Defect	A birth defect involving the heart
Heart Attack	n/a
Cardiomyopathy	A disease or disorder of the heart muscle.
Heart Valve Disease	Any disease involving the bicuspid, tricuspid, pulmonic or aortic valves in the heart. Most often a term like "stenosis" or "regurgitation" is used to describe the problem.
Heart Murmur	An extra sound associated with the heartbeat. Many heart murmurs are not considered problematic, but it is important to note if you have one.
Endocarditis	An infection or inflammation of the heart.
High Blood Pressure	A condition in which the pressure of the blood, especially in the arteries, is abnor mally high. Also called hypertension. In adults this would correspond to blood pressures consistently higher than 140/90.
High Cholesterol	A condition in which you develop fatty deposits in your blood vessels and can increase your risk of heart attack.
Vision Impairment	This includes any disorder of vision from complete blindness to very minor near or far sightedness that is fully correctable with glasses or contacts.
Hearing Impairment	This includes any disorder of hearing from complete deafness to any deficit in hearing for which a hearing aid would be prescribed.
Enlarged Spleen	Also known as splenomegaly. An enlarged or inflamed spleen (an organ in your stomach area that helps filter the blood and is part of the immune system).

Single Kidney	If you only have one kidney (because you had one removed or you were born with only one kidney)
Osteoporosis	A disease that means you are at risk for easily breaking your bones because they have become weak.
Osteopenia	It is the first sign and stage of the worse version of the disease, Osteoporosis (described above)
Sickle Cell Disease	Includes types of blood disorders, like sickle cell anemia
Sickle Cell Trait	A trait that you inherited from a parent that puts you at risk for blood disorders like sickle cell anemia. You may not yet have the disease, just a risk to develop it.
Easy Bleeding	This includes bleeding disorders such as hemophilia, Von Willebrand disease, or any other platelet or clotting factor disorder that causes abnormally long bleeding times. This would also include any athlete who is taking medications that inhibit blood clotting.
Stroke/TIA	Stroke = When blood doesn't flow to part of the brain. This can prevent oxygen from reaching the brain and result in possible brain damage. TIA = Transient Ischemic Attack. This is a stroke-like attack where blood flow to parts of the brain stops for a short time. Usually a TIA has no lasting negative effect on the individual.
Concussions	A brain injury caused by a sudden hit to the head which shakes the brain inside the skull.
Asthma	Difficulty breathing.
Diabetes	Disease of high blood sugar.
Hepatitis	Inflammation or enlargement of the liver.
Urinary Discomfort	Pain or burning feeling when you use the bathroom. This can be a symptom of an infection.
Spina Bifida	Birth defect resulting in which the spinal cord does not develop properly.
Arthritis	Painful inflammation and stiffness of the joints.
Heat Illness	When you become ill after exercising or being in hot temperatures
Broken Bones	n/a
Dislocated Joints	n/a

21) **Menstrual History** – If the athlete is female, specify the date of the athlete's last menstrual period. If the exact date is unknown specify approximately how long it has been since the athlete had her period.

22) **Possible Neurological Symptoms** – This section includes several conditions that may be symptoms of neurological conditions, such as spinal cord compression or atlanto-axial instability.

Difficulty controlling bowels or bladder	n/a
Numbness or tingling in legs, arms, hands or feet	Lack of feeling or a feeling like "pins and needles"
Weakness in legs, arms, hands or feet	n/a
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	A burning or stinging pain in your neck, back, shoulders, arms, hands, legs, or feet.
Head Tilt	When the head often tilts/leans to one side
Spasticity	A constant stiffness or tightness of the muscles that can impact normal movement, speech or walking stride.
Paralysis	The loss of the ability to move (and sometimes to feel anything) in part or most of the body.

23) **List any other past or ongoing medical conditions** for which the athlete required or currently requires treatment which have not been included in other places on this form. Please note if the athlete is pregnant

24) **Medications** – List all of the athlete's current medications including: prescription drugs, over-the-counter (drugstore) medications, vitamins, herbal supplements, inhalers, birth control pills (or shots) or hormone therapy

25) **Self-Administration** – Check whether the athlete is able to take medications by himself or herself without reminders or assistance

26) **Person completing the form** – List the name and contact information for the person who completed the form (e.g., the athlete, the parent, coach, home aide). This is just in case the local Special Olympics Program needs to follow-up with the individual that completed the medical form for missing information or clarification

Physical Exam Instructions (Page 3)

(To be Completed by a Licensed Physician or Other Licensed Healthcare Provider such as a Registered Nurse Practitioner or Physician Assistant with prescriptive authority)

1) **Height** – Measured in centimeters or inches

2) **Weight** – Measured in kilograms or pounds

3) **Body Mass Index or Body Fat %** - If possible, indicate the Body Mass Index (BMI) or body fat percentage of the athlete

4) **Temperature** – Measured in centigrade or Fahrenheit. Increased temperature may indicate an acute infection that may place the athlete at risk during sports participation

5) **Pulse** – Measured in beats per minute. Extraordinarily high or low pulse rates may be associated with medical issues that may place the athlete at additional risk during sports participation

6) **O_2 Sat**. – Blood oxygen saturation percent, as measured by a pulse oximeter at room air. Decreased blood oxygenation may be an indication of significant cardiac or pulmonary abnormalities that may place the athlete at risk during sports participation. Anything below 90% should not be cleared for participation

7) **Blood Pressure** – Measured in mmHg. First, measure blood pressure in the right arm of a calm and rested athlete. If the blood pressure is hypertensive (greater than 140/90) then measure the blood pressure in the left arm to confirm. If the blood pressure in the right arm is normal, measuring the blood pressure in the left arm is not necessary. A difference between right and left blood pressures of more than 20 mmHg may indicate an aortic anomaly that may place the athlete at risk during sports participation. Significant hypertension (stage II hypertension in children or adults) may place the athlete at additional risk during sports participation

   a. Blood pressure above 160/100 should not be cleared to participate until the blood pressure has dropped below that range

8) **Vision** – Test the athlete's ability to read the 20/40 line only on a distance vision chart (Lea chart is preferred) with each eye covered separately. If the athlete's vision cannot be determined for a specific eye, mark "N/A".

Physical Exam – The physical exam performed on the athlete should be thorough. The examiner should pay close attention to any signs or symptoms of cardiopulmonary or neurological conditions – especially new or changing neurological conditions. Documentation of every part of the physical exam is absolutely necessary. Additional physical findings not described on the form may be noted in a subsequent section below.

9)
   b. *NOTE: In the MedFest environment, genitourinary, breast and rectal examinations are not performed, however these portions of the physical exam may be performed in an "individual exam" according to the preference of the examiner.*

   c. *Examiner's Tip: The first column of responses to the different parameters of the physical exam represent what would traditionally be called the "within normal limits" response. Drawing a straight line down this column on both sides signifies that the physical exam was completely normal and unremarkable.*

10) **Spinal Cord Compression or Atlantoaxial Instability (AAI)** – The medical health history form asks a series of questions about possible neurological symptoms that could be associated spinal cord compression and/or AAI. These appear in the middle left side of the page. The physical exam form asks the examiner to assess for signs of possible spinal cord compression and/or AAI. The presence of any signs or symptoms should be taken seriously, as the presence of spinal cord compression and/or AAI is associated with significant risk of spinal cord injury in the sports environment. Athletes who describe incontinence or any numbness, weakness, pain or discomfort, head tilt, spasticity or paralysis of any part of the body, especially if any of those symptoms are new or have worsened within the past 3 years may need additional neurological evaluation before they can be cleared to participate in any Special Olympics sports. Likewise, abnormal reflexes, gait, spasticity, tremors, changes in mobility, strength or sensitivity may also suggest that an athlete needs additional neurological evaluation. It should be noted that not all neurological signs and symptoms (such as those that are stable and long-standing) will require further neurological evaluation.

   d. In this section, the examiner must specify if there are any signs or symptoms that could be associated with spinal cord compression and/or AAI. If so, the athlete may not be cleared for sports participation until they have been seen by a neurologist, neurosurgeon or other physician qualified to determine, definitively, if participation in sports activity, in the presence of the noted neurological signs and symptoms, will be safe for the athlete.

11) **Athlete Clearance to Participate** – Specify if the athlete is able (medically safe) to participate in Special Olympics or not. Generally, clearance for sports is an all-or-none phenomenon. However, in some cases the physician may opt to clear the athlete for some sports or for all sports with some limitations. For example, an athlete who has had seizures within the past year may be cleared with the recommendation to not participate in certain higher risk sports for people with seizures, such as swimming, sailing, bicycling, downhill skiing, or equestrian events. Athletes with acute infections may be cleared to participate once the infection has been adequately treated.

   a. **If an athlete is not cleared for sports participation, a reason must be given.** The most common reasons for not clearing an athlete for participation are noted (concerning cardiac exam, concerning neurological exam, acute infection, stage II hypertension or higher, oxygen saturations of less than 90%, hepatomegaly or splenomegaly). If the athlete is not cleared for another reason, please describe the reason in the open box provided.

12) **Additional Examiner Notes** – The examiner may write any other information the examiner wishes to provide including additional instructions, examinations performed or not performed or other relevant information to the exam or the athlete's health.

13) **Referrals** – Whether or not the athlete is cleared for sports participation, the examiner may wish to recommend that the athlete be referred to another medical professional for additional evaluation. The most common specialists to refer to (cardiologist, neurologist, primary care physician, vision specialist, hearing specialist, dentist or dental hygienist, podiatrist, physical therapist or nutritionist) are provided in this section. Other referrals may be handwritten in the "Other" box. These referrals do not impact the athlete's clearance.

14) **Examiner's Signature and Information** – The physician or other licensed healthcare provider performing the exam and providing medical clearance for the athlete must sign the bottom of page 3. Additionally, they should fill in the date of the exam, print their name, as well as put their email address, phone number and medical license number in case of questions or concerns.

Medical Referral Form Instructions (Page 4)

(To be Completed by Additional Physicians for further evaluation only if athlete is not cleared on page 3)

15) **Further Medical Evaluation** – Page 4 consists of a medical evaluation form only if the athlete needed further examination before clearance.

   e. This page is only to be used if the athlete has been examined first by a physician and was denied sports clearance based on the need for further medical evaluation. To complete this form (and thus to complete the medical clearance process), the additional physician must print his or her name and medical specialty, state the purpose for the referral and state whether or not the athlete may participate in sports after the assessment of the athlete. Additional notes, restrictions, qualifying comments or referrals may be entered in the space for "additional examiner notes". Finally, the additional examining physician should list his or her email address, phone number, license number as well as sign and date the referral form. If more than one additional medical examination is needed for clearance, then this page should be copied and each examining physician completes the form