

# U.S. Athlete MEDICAL Form

Required for all athletes participating in Special Olympics.

**Special Olympics**  
Maryland



Local Area/County Program: \_\_\_\_\_

**Athlete Information - Mandatory - To be completed by the athlete or parent/guardian/caregiver.**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Female Male Other

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Home address: \_\_\_\_\_

**Optional - Check all that apply:**

Race / Ethnicity	American Indian / Alaskan Native	Asian American		
	Black / African American	Hispanic / Latino		
	Middle Eastern / North African	Native Hawaiian / Other Pacific Islander		
	White / Caucasian	Unknown		
	Other: _____	Prefer not to answer		
Language(s) Spoken by Athlete	English	French	Spanish	American Sign Language (ASL)
	Other (please list): _____			

**Parent/Guardian Information - Required if a minor or otherwise has a legal guardian.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship to athlete: \_\_\_\_\_

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Home address: \_\_\_\_\_

**Emergency Contact - Mandatory Same as Parent/Guardian**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

**Associated Conditions - Mandatory**

Associated Conditions	Autism	Cerebral Palsy	Down Syndrome	Fetal Alcohol Syndrome
	Marfan Syndrome	Spina Bifida	Epilepsy	Fragile X Syndrome
	Other	Unknown		
Please specify other known intellectual disability diagnoses:				

**Assistive Devices and Accommodations - Mandatory - Do you use any of the following? Check all that apply:**

Mobility	Walker	Braces or crutches	Wheelchair	Removable orthotics
	Prosthetics	None		
Lifestyle Aids	CPAP	Dentures	Glasses, contact lenses, or protective eyewear	
	None			
Communications	Hearing Aid	Communication devices	Sign Language	None
Medical Devices	Implantable cardioverter defibrillator (ICD)	Implantable device for seizure management		
	VP Shunt	Pacemaker	None	

Do you have a specific dietary requirement?	Yes	No	If yes, please specify:
Do you use other assistive devices?	Yes	No	If yes, please specify:

**General Health Questions - *Mandatory***

Do you have a heart condition?	Yes	No
Do you have asthma?	Yes	No
Do you have diabetes that requires you to take insulin?	Yes	No
Do you have a vision impairment?	Yes	No
Do you have a hearing impairment?	Yes	No
Do you have a bleeding disorder?	Yes	No
Has a doctor ever limited your participation in sports?	Yes	No
Do you have epilepsy or any type of seizure disorder?	Yes	No
Do you have sickle cell disease?	Yes	No

Have you ever had a concussion?	Yes	No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	Yes	No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen or similar device?	Yes	No	If yes, please specify if it is to any of the following: Insect stings                      Medication/drugs Food                                      Latex Other (please specify): _____

**Medication and Treatment - *Mandatory* - Please list:**

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

Yes                      No

**If yes, please list:**

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: \_\_\_\_\_

Today's date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this form being completed by someone other than the athlete?                      Yes                      No

If yes, please select the relationship to athlete:

Relationship to athlete:      Parent/guardian                      Caregiver                      Family member                      Healthcare provider                      Coach                      Other

***Special Olympics encourages all participants to get a yearly physical examination.***

# Athlete Medical Form – PHYSICAL EXAM

(to be completed by a Medical Professional only)



Athlete's Name:

## MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

Height	Weight	BMI (optional)	Temperature	Pulse	O <sub>2</sub> Sat	Blood Pressure	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					

### ATLANTO-AXIAL INSTABILITY (AAI)

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

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

### RECOMMENDATIONS (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 use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance..

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

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions/limitations →

This athlete **MAY NOT participate** in Special Olympics sports at this time and **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 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:	
Licensed Medical Examiner's Signature	Date of Exam	Phone:	License:

## WAIVERS, RELEASES, AND POLICIES

Please read the following information and check boxes fully before signing.

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.
3. **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.
  - I do NOT consent to blood transfusions.

**(If either box above is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)**
4. **Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.
5. **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 have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."
6. **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 contact information for communicating with me about Special Olympics.
- sharing my personal information confidentially with (i) researchers such as universities and public health agencies 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 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.

**Privacy Policy.** Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at [www.SpecialOlympics.org/Privacy-Policy](http://www.SpecialOlympics.org/Privacy-Policy).

### **SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY (For athlete with Down syndrome only)**

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

**WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION**

In consideration of being allowed to participate in any way in Special Olympics activities, the undersigned acknowledges, appreciates, and agrees that:

- 1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;
- 2. If I observe any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest Special Olympics representative immediately; and,
- 3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

<p>Athlete Name: _____</p> <p style="text-align: center;"><b>ATHLETE SIGNATURE</b> (required for adult athlete with capacity to sign legal documents)</p> <p>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</p> <p>Athlete Signature: _____ Date (mm/dd/yyyy): ____/____/____</p> <p style="text-align: center;"><b>PARENT/GUARDIAN SIGNATURE</b> (required for athlete who is a minor or lacks capacity to sign legal documents)</p> <p>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.</p> <p>Parent/Guardian Signature: _____ Date (mm/dd/yyyy): ____/____/____</p> <p>Printed Name: _____ Relationship: _____</p>	<p><b>Signatures in this section MUST be either "live" handwritten signatures or valid electronic signatures (including the e-signature provider's certification stamp). Typing in a name is NOT sufficient and will NOT be accepted.</b></p>
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**EVALUATION AND RESEARCH (Optional)**

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

Yes                      No

**Once reviewed and confirmed as complete by SOMD HQ, this Athlete Registration Form is valid for 12 months from the date of the above signature. It must be completed and submitted annually.**