**FORM C1 – Athlete Medical Form – Page 1**

|  |
| --- |
| SECTION 1 DEMOGRAPHICS |
|  | Athlete |  | Unified Sports Partner |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Delegation: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | SO Region  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Family Name |  | First Name |  | Middle Initial  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of Birth dd-mm-yyyy |  |  |  | Sport |  |  |  |  |  |  |  |  |  |  |  |
| **Emergency contact Information** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to Athlete |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Family Name |  | First Name |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mailing Address |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| City |  | State/Province |  | Country |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Telephone Number Day |  | Telephone Number Night |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Health Insurance Provider | Policy Number |
| Religious objections to medical treatment: Please specify and refer to instructions |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |
| **SECTION 2 HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER** |
| Yes | No |  | Yes | No |  |
| [ ]  | [ ]  | \*Heart disease / heart defect / high blood pressure | [ ]  | [ ]  |  Allergy: |
| [ ]  | [ ]  | \*Chest pain | [ ]  | [ ]  | Medicines: |  |  |
| [ ]  | [ ]  | \*Seizures / epilepsy/fainting spells | [ ]  | [ ]  | Food: |  |  |
| [ ]  | [ ]  | \*Diabetes | [ ]  | [ ]  | Insect stings/bites: |  |  |
| [ ]  | [ ]  | \*Concussion or serious head injury | [ ]  | [ ]  |  Special diet |
| [ ]  | [ ]  | \*Major surgery or serious illness | [ ]  | [ ]  |  \*Asthma |
| [ ]  | [ ]  | Heat stroke / exhaustion | [ ]  | [ ]  |  Tobacco use |
| [ ]  | [ ]  | \*Blindness / visual problem | [ ]  | [ ]  |  Easy bleeding |
| [ ]  | [ ]  | Contact lenses / glasses | [ ]  | [ ]  |  Emotional / psychiatric / behavioral |
| [ ]  | [ ]  | Hearing loss / hearing aid | [ ]  | [ ]  |  Sickle cell trait or disease |
| [ ]  | [ ]  | Bone or joint problem | [ ]  | [ ]  |  Immunizations up to date, including tetanus  |
| Date of most recent tetanus immunization \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | [ ]  | [ ]  |  Other |  |  |
| (\*) Requires physical examination  |  |  |
| **Medications:** Please print medication name, amount, date prescribed and number of times per day medication are given. |
|  | Medication Name | Dosage | DatePrescribed | Times per day | Medication Name | Dosage | Date Prescribed | Times per day |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Signature of parent/caregiver/adult Athlete: |  | Date | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
|  |  |  |  |

**FORM C1 – Athlete Medical Form – Page 2**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Family Name |  | First Name |  | Middle Initial  |

|  |
| --- |
|  Does this Athlete have Down Syndrome? Yes [ ]  No [ ]  |

***If yes, you must complete the box below***

|  |
| --- |
| **ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME** |
| EXAMINER’S NOTE: If the Athlete has Down Syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial 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: butterfly events, individual medley events and diving starts in swimming, diving, pentathlon, high jump, equestrian sports, artistic gymnastics, football (soccer) team competition, snowboarding, judo, alpine skiing and any warm-up exercise placing undue stress on the head and neck. |
| Yes | No |  |
| [ ]  | [ ]  | Has an x-ray evaluation for Atlanto-axial instability been done? |
| [ ]  | [ ]  | If yes, was it positive for Atlanto-axial instability? (positive indicates that the Atlanto-dens interval is 5mm or more) If YES, Form C3-Special Release for Athletes With Atlanto-Axial Instability MUST be Completed |

|  |
| --- |
| **PHYSICAL EXAMINATION** |
| Blood pressure: \_\_\_\_\_/\_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ |
| Normal/Abnormal |  | Normal/Abnormal |  | Normal/Abnormal |  |
| [ ]  | [ ]  | Vision | [ ]  | [ ]  | Cardiovascular system | [ ]  | [ ]  | Cranial nerves |
| [ ]  | [ ]  | Hearing | [ ]  | [ ]  | Respiratory system | [ ]  | [ ]  | Coordination |
| [ ]  | [ ]  | Oral cavity | [ ]  | [ ]  | Gastrointestinal system | [ ]  | [ ]  | Reflexes |
| [ ]  | [ ]  | Neck | [ ]  | [ ]  | Genitourinary system |  |  |  |
| [ ]  | [ ]  | Extremities | [ ]  | [ ]  | Skin |  |  |
| Other: |  |  |
| Primary MR Etiology/Category: | (If known)  |  |
| I have reviewed the above health information and have performed the above examination on this Athlete within the past 6 months and certify that the Athlete can participate in Special Olympics. |
| RESTRICTIONS: |  |  |
| EXAMINER’S SIGNATURE: |  | Date | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| EXAMINER’S NAME: |  |  |  |
| ADDRESS: |  |  |
|  |  | PHONE: |  |  |
|  |