

Athlete Medical Form

Accessibility Version

Special Olympics



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

First name: _____

Last name: _____

Preferred name: _____

Date of birth (mm/dd/yyyy): ____/____/____

Gender: ☒ Female ☐ Male ☐ Other

Email: _____

Phone number: _____

☐ Mobile ☐ Landline

Postal address: _____

Country: _____

Emergency Contact

First name: _____

Last name: _____

Phone number: _____

☐ Mobile ☐ Landline

Relationship to athlete:

☐ Parent/guardian
☐ Healthcare provider

☐ Caregiver
☐ Coach

☐ Family member
☐ Other

Qualifying and Associated Conditions - *Check all that apply:*

Associated
Conditions:

Autism	Down Syndrome	Cerebral Palsy
Epilepsy	Fragile X Syndrome	Fetal Alcohol Syndrome
Spina Bifida	Marfan Syndrome	
Other	None	

Please specify other
known intellectual
disability:

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

Mobility:

Walker	Braces or crutches	Wheelchair
Prosthetics	Removable orthotics	None

Lifestyle Aids:

CPAP	Colostomy	Dentures
Inhaler	Glasses or contact lenses or protective eye wear	None

Communications:

Hearing aid	Communication devices	Sign language
None		

Medical Devices:

Implantable cardioverter defibrillator (ICD)	VP shunt
Implantable device for seizure management	Pacemaker
Spinal cord stimulator	None

List specific
dietary
requirements:

Other assistive
devices and
accommodations:

General Health Questions - *Have you ever been diagnosed with or experienced any of the following?*

High blood pressure	Yes	No	Heat illness	Yes	No
Cardiac condition	Yes	No	Coeliac disease	Yes	No
Diabetes	Yes	No	Enlarged spleen	Yes	No
Kidney disease	Yes	No	Hearing impairment	Yes	No
Bleeding disorders	Yes	No	Visual impairment	Yes	No
Anemia	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Non-verbal	Yes	No

Have you ever had a head injury or concussion?.....	Yes	No
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?.....	Yes	No
Has any family member or relative died of heart problems or of sudden death before age 50?.....	Yes	No
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?.....	Yes	No
Have you had COVID-19?.....	Yes	No
Have you been immunized for COVID-19?.....	Yes	No

Do you have an allergy to any of the following?

Dust	Foods	Insects	Animals
Plants	Grasses	Pollen	Drugs or medicine
Latex	Other	None	

Please specify allergies:

Have you had any surgeries?

Yes

No

If yes, please list all:

Did you ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?

Yes

No

If yes, please specify:

Has a doctor ever limited your participation in sports?

Yes

No

If yes, please specify:

Do you have epilepsy or any type of seizure disorder?

Yes

No

If yes, please specify:

Have you had any broken bones or dislocated joints?

Yes

No

If yes, please specify:

Do you have liver disease?

Yes

No

If yes, please specify:

Do you have lung disease?

Yes

No

If yes, please specify:

Do you have heart disease?

Yes

No

If yes, please specify:

Do you have behavioral, mental health, and/or sensory conditions?

Yes

No

If yes, please specify:

Medication and Treatment - *Please list:*

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

Medication, Vitamin,
or Supplement Name

Dosage Times
per day

Medication, Vitamin,
or Supplement Name

Dosage Times
per day

Eligibility to Participate

Every person with an intellectual disability who is at least eight years of age is eligible to participate in Special Olympics. A person is considered to have an intellectual disability for purposes of determining his or her eligibility to participate in Special Olympics if that person satisfies any one of the following requirements:

(1) The person has been identified by an agency or professional as having an intellectual disability as determined by their localities; or

(2) The person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted within the professional community in that Accredited Program's nation as being a reliable measurement of the existence of a cognitive delay; or

(3) The person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as IQ) and in adaptive skills (such as in recreation, work, independent living, self-direction, or self-care).

However, persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes, but may be eligible to volunteer for Special Olympics.

Today's date (mm/dd/yyyy): ____/____/____

Signature of person completing the form: _____

Is this form being completed by someone other than the athlete?

Yes

No

If form is being completed by someone other than the athlete, please select the relationship to athlete.

Relationship to athlete:

Parent/Guardian

Caregiver

Family Member

Healthcare Provider

Coach

Other

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

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

Athlete first and last name: _____

Date of birth (mm/dd/yyyy): ____/____/____

Height (in or cm)		Pulse (bpm)	
Weight (lb or kg)		O2sat (%)	
Waist circumference (in or cm)		Blood pressure (mmHg)	/
Temperature (°F or °C)		Vision	os ____/20 od ____/20

Medical

Eyes, ears, nose, and throat: include pupils, hearing

Normal

Abnormal

Findings:

Heart: include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)

Normal

Abnormal

Findings:

Lungs

Normal

Abnormal

Findings:

Abdomen

Normal

Abnormal

Findings:

Skin: HSV, MRSA, or tinea corporis

Normal

Abnormal

Findings:

Neurological

Normal

Abnormal

Findings:

Musculoskeletal

Neck

Normal

Abnormal

Findings:

Back

Normal

Abnormal

Findings:

Shoulder
and arm

Normal

Abnormal

Findings:

Elbow and
forearm

Normal

Abnormal

Findings:

Wrist, hand,
and fingers

Normal

Abnormal

Findings:

Hip and thigh

Normal

Abnormal

Findings:

Knee

Normal

Abnormal

Findings:

Lower leg
and ankle

Normal

Abnormal

Findings:

Foot and toes

Normal

Abnormal

Findings:

Is there anything else Special Olympics should know about the health or wellbeing of this athlete?

Use additional pages if necessary.

MEDICAL ELIGIBILITY FOR SPORT (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 provide information regarding the licensed healthcare provider below. That provider should complete a referral below and second physician for referral should complete the Athlete Physical Information portion.

Medically eligible for all sports without restriction.

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____

Not medically eligible to participate in the following sports:

Not medically eligible pending further evaluation of:

Not medically eligible for any sports

I have examined the athlete named on this form and completed the pre-participation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional: _____

Date (mm/dd/yyyy): ____/____/____ Phone number: _____

Address: _____

Signature: _____

NPI or License number: _____ License type (MD, DO, NP, or PA): _____