Special Olympics
FUNfitness

Healthy Athletes Screening Form

Station 1: Check In

First Name: _____ Last Name: _____ HAS ID: _____

Event Date: ____/____/_____ Date of Birth (mm/dd/yyyy): ____/____/_____ Age (years): _____

Event Location (City, State/Province or Country): _____ Delegation/SO Program: _____

Gender: ◯Female ◯Male ◯Prefer not to answer Athlete Status: ◯Athlete ◯Unified partner ◯Non-athlete with IDD ◯Other

Sport: _____ Cell Phone: _____ Number is: ◯ Athlete's ◯ Parent's/Guardian's

Providing a phone number is optional. It will be used to send a text reminder if any follow-up is recommended after screening.

Select any current and/or previous medical history, diseases or injuries that apply to you that may affect screening results.

◯ No conditions nor medical history that may affect this screening ◯ I don't know ◯ Did not answer

☐ Breathing problems ☐ Heart problems ☐ Fever, illness, infection

☐ Current pain

If checked, please indicate where:

☐ Head and/or neck ☐ Shoulder ☐ Elbow ☐ Wrist and/or hand
☐ Trunk and/or back ☐ Hip ☐ Knee ☐ Ankle and/or foot ☐ Other: _____

☐ Current injury (e.g., sprain/strain)

If checked, please indicate where:

☐ Head and/or neck ☐ Shoulder ☐ Elbow ☐ Wrist and/or hand
☐ Trunk and/or back ☐ Hip ☐ Knee ☐ Ankle and/or foot ☐ Other: _____

☐ Other history, disease, or injury

Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

In the past 12 months, how many times have you fallen?

◯ 0 times ◯ 1 time ◯ 2 times ◯ ≥3 times ◯ I don't know ◯ Did not answer

Do you use any assistive devices to aid your mobility?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

If yes, please indicate type:

☐ Walker ☐ Crutches ☐ Wheelchair ☐ Other: _____

Do you typically wear a brace/splint, orthotic, or prosthetic?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

If yes, please indicate those devices that apply and location for each below:

☐ Brace(s)/Splint(s):	☐ Shoulder	☐ Elbow	☐ Wrist and/or hand	☐ Back	☐ Hip	☐ Knee	☐ Ankle and/or foot
☐ Orthotic(s):	☐ Shoulder	☐ Elbow	☐ Wrist and/or hand	☐ Back	☐ Hip	☐ Knee	☐ Ankle and/or foot
☐ Prosthetic(s):	☐ Shoulder	☐ Elbow	☐ Wrist and/or hand	☐ Back	☐ Hip	☐ Knee	☐ Ankle and/or foot

In a typical week, on how many days do you do moderate-intensity sports, fitness, or recreational activities?

(Moderate intensity sports, fitness, or recreational activities cause small increases in breathing or heart rate and are done for at least 10 minutes continuously. Examples include dancing, swimming, or bicycling.)

◯ 0 days ◯ 1 day ◯ 2 days ◯ 3 days ◯ 4 days ◯ 5 days ◯ 6 days
◯ Everyday ◯ I don't know ◯ Did not answer

In a typical week, on how many days do you do vigorous-intensity sports, fitness, or recreational activities?

(Vigorous-intensity activities causes large increases in breathing or heart rate and are done for at least 10 minutes continuously. Examples include sprinting, running upstairs, fast bicycling, or playing basketball or soccer.)

◯ 0 days ◯ 1 day ◯ 2 days ◯ 3 days ◯ 4 days ◯ 5 days ◯ 6 days
◯ Everyday ◯ I don't know ◯ Did not answer

Do you routinely participate in any other exercise activities such as strengthening, stretching, balance or aerobics?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

If yes, how much of this is related to Special Olympics training, practice, or competition?

◯ None ◯ Some ◯ Most ◯ All

If no, why not?

☐ No available exercise facilities ☐ No equipment or clothes ☐ No transportation ☐ No money

☐ No fitness person to help me ☐ No one to exercise with ☐ Physically unable ☐ Not safe ☐ No interest

☐ Other (please specify): _____

Are you under routine care from a doctor?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

If yes, what is their specialty?

◯ Primary Care Provider ◯ Physiotherapist ◯ Orthopedist ◯ Cardiologist ◯ Podiatrist

◯ Other (please specify): _____

When was your last visit: _____

Are you currently participating in a Special Olympics Fitness program?

(SO Fitness programs include SO FitNow App, Unified Fitness Club, Fit 5, School of Strength, SO Fitness Challenges, Fitness Captains, etc.)

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

Follow-up recommended? *Check 'Yes' if Athlete indicated they do moderate- and/or vigorous-intensity exercise < 3 days/week*

◯ **Yes** ◯ **No**

Station 2: Flexibility

Screener's Name:

Modified V-Sit and Reach Test	**Distance reached: + / - _____ cm**	
	Did the athlete indicate pain during testing? ◯ Yes ◯ No ◯ Did not answer	
	Unable to test because athlete: ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other:* _____	
	Follow-up recommended? ◯ **Yes** ◯ **No** *Check 'Yes' if distance reached is < 20 cm with pain or pain is indicated at any point during testing*	
Weight Bearing Lunge Test	**LEFT: Distance from wall to achieve position: _____cm**	**RIGHT: Distance from wall to achieve position: _____cm**
	Did the athlete indicate pain during testing? ◯ Yes ◯ No ◯ Did not answer	
	Unable to test because athlete: ☐ *Left* ☐ *Right* ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other:* _____	
	Follow-up recommended? ◯ **Yes** ◯ **No** *Check 'Yes' if distance from wall to achieve position is < 13 cm with pain or pain is indicated at any point during testing*	
Modified Apley's Scratch Test	**LEFT: Distance between fingertips: + / - _____ cm**	**RIGHT: Distance between fingertips: + / - ____ cm**
	Did the athlete indicate pain during testing? ◯ Yes ◯ No ◯ Did not answer	
	Unable to test because athlete: ☐ *Left* ☐ *Right* ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other:* _____	
	Follow-up recommended? ◯ **Yes** ◯ **No** *Check 'Yes' if distance between non-approximated fingertips is > 5 cm with pain or pain is indicated at any point during testing*	

Station 3: Strength

Screener's Name:	

10 time Sit-to-Stand Test	Is the athlete able to complete a full stand with hips and knees extended? ◯ Yes ◯ No	
	Time: _____ seconds	
	Did the athlete indicate pain during testing? ◯ Yes ◯ No ◯ Did not answer	
	Unable to test because athlete: ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other:* _____	
	Follow-up recommended? ◯ **Yes** ◯ **No**	*Check 'Yes' if time to complete test is > 20 seconds and/or pain is indicated at any point during testing*
Hand Grip Dynamometry Test	Dominant Hand: ◯ Left ◯ Right	
	LEFT: Trial 1: _____ kg	RIGHT: Trial 1: _____ kg
	LEFT: Trial 2: _____ kg	RIGHT: Trial 2: _____ kg
	LEFT: Trial 3: _____ kg	RIGHT: Trial 3: _____ kg
	LEFT: Highest: _____ kg	**RIGHT: Highest: _____ kg**
	Did the athlete indicate pain during testing? ◯ Yes ◯ No ◯ Did not answer	
	Unable to test because athlete: ☐ *Left* ☐ *Right* ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other:* _____	
	Follow-up recommended? ◯ **Yes** ◯ **No**	*Check 'Yes' if any of the following are true: 1) The difference between left and right grip strength is > 20%, 2) Overall grip strength appears to be below average based on clinical judgment, 3) Pain is indicated at any point during testing*
Isometric Push-Up Test	**Time: _____ seconds** **Stop test after 40 seconds*	
	Did the athlete indicate pain during testing? ◯ Yes ◯ No ◯ Did not answer	
	Unable to test because athlete: ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other:* _____	
	Follow-up recommended? ◯ **Yes** ◯ **No**	*Check 'Yes' if time in isometric push-up < 29 seconds and/or pain is indicated at any point during testing*

Seated Push-Up Test	****Only tested if athlete is unable to attempt Isometric Push-Up test***
	Time: _____ seconds
	Did the athlete indicate pain during testing? ◯ Yes ◯ No ◯ Did not answer
	Unable to test because athlete: ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other:* _____
	Follow-up recommended? ◯ **Yes** ◯ **No** *Check 'Yes' if time in seated push-up < 5 seconds and/or pain is indicated at any point during testing*

Station 4: Balance

Screener's Name:

Tandem Stance	**LEFT foot behind: _____ seconds** **Stop test after 30 seconds*	**RIGHT foot behind: _____ seconds** **Stop test after 30 seconds*
	Unable to test because athlete: ☐ *Left* ☐ *Right* ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other: _____*	
	Follow-up recommended? *Check 'Yes' if time in left and/or right tandem stance < 20 seconds* ◯ **Yes** ◯ **No**	
Single Leg Stance: Eyes Open	**LEFT foot: _____ seconds** **Stop test after 30 seconds*	**RIGHT foot: _____ seconds** **Stop test after 30 seconds*
	Unable to test because athlete: ☐ *Left* ☐ *Right* ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other: _____*	
	Follow-up recommended? *Check 'Yes' if time in left and/or right Single Leg Stance: Eyes Open < 20 seconds* ◯ **Yes** ◯ **No**	
Single Leg Stance: Eyes Closed	***If unable to complete both left and right Single Leg Stance: Eyes Open for at least 10 seconds, do not perform Single Leg Stance: Eyes Closed***	
	LEFT foot: _____ seconds **Stop test after 30 seconds*	**RIGHT foot: _____ seconds** **Stop test after 30 seconds*
	Unable to test because athlete: ☐ *Left* ☐ *Right* ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other: _____*	
	Follow-up recommended? *Check 'Yes' if time in left and/or right Single Leg Stance: Eyes Closed < 10 seconds* ◯ **Yes** ◯ **No**	
Timed Up and Go (TUG)	Trial 1: _____ seconds	
	Trial 2: _____ seconds	
	Average time: _____ seconds	
	Unable to test because athlete: ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other: _____*	
	Follow-up recommended? *Check 'Yes' if average time to complete Timed Up and Go > 12 seconds* ◯ **Yes** ◯ **No**	

Seated Functional Reach: Forward & Lateral	****Only tested if athlete is non-ambulatory and/or unable to stand and walk for above testing***		
	FORWARD:	**LEFT: _____cm**	**RIGHT: _____cm**
	LATERAL:	**LEFT: _____cm**	**RIGHT: _____cm**
	Unable to test because athlete: ☐ *Left* ☐ *Right* ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other: _____*		
	Follow-up recommended? *Check 'Yes' if forward and lateral distance on Seated Functional Reach < 15 cm* ◯ **Yes** ◯ **No**		

Station 5: Aerobic Fitness

Screener's Name:

Is the athlete ambulatory? ◯ Yes ◯ No

Two-Minute Step Test (2MST)	***Only tested if athlete is ambulatory**
	Number of Steps: _____
	Unable to test because athlete: ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other: _____*
	Follow-up recommended? ◯ **Yes** ◯ **No** *Check 'Yes' if Athlete completes < 80 steps and/or an abnormal physiological response to testing is observed* **Clinician should use overall clinical judgement to make recommendation for results of this station, above cut-offs are minimum suggested parameters, but some athletes could still present with need for referral outside of these parameters.*

Six-Minute Push Test	***Only tested if athlete is non-ambulatory and using a wheelchair**
	Distance: _____ meters
	Unable to test because athlete: ◯ *Refused to perform* ◯ *Unable to perform* ◯ *Unable to understand* ◯ *Other: _____*
	Follow-up recommended? ◯ **Yes** ◯ **No** *Check 'Yes' based on clinical judgment of athlete response to testing, such as an abnormal physiological response to testing is observed* **Clinician should use overall clinical judgement to make recommendation for results of this station, above cut-offs are minimum suggested parameters, but some athletes could still present with need for referral outside of these parameters.*

How is HR being measured? ◯ Manual pulse check ◯ Pulse oximeter		
Pre-exercise:	**Heart rate (beats/min): _____**	**O2 saturation (%): _____**
End of exercise:	**Heart rate (beats/min): _____**	**O2 saturation (%): _____**
1-minute post-exercise:	**Heart rate (beats/min): _____**	**O2 saturation (%): _____**

Was an abnormal physiological response to testing observed?

◯ Yes ◯ No

If yes, select any/all that apply to describe the athlete's response to testing:

☐ Abnormal heart rate response ☐ Abnormal respiratory rate ☐ Excessive sweating ☐ Signs of cyanosis

☐ Other: _____

Station 6: Check Out

Screener's Name:

Screening Completion

Was the screening unable to be completed and/or concluded prior to completion for any reason?

◯ Screening Complete ◯ Screening Incomplete

If screening incomplete, please describe: _____

Extra resources provided onsite:

☐ Exercise Bands ☐ Stretching Straps ☐ Fitness Manuals (e.g., Fit 5, HIGH 5 for Fitness, etc.) ☐ Other: _____

Follow-up recommended? ◯ Yes ◯ No

If yes, please select appropriate provider(s)/program below and select the most elevated referral type based on results of screening.

☐ **Fitness Programming**	◯ Routine Follow-up	Continue with current SO Fitness program. *Suggested if currently participating in local fitness programming.*
	◯ Non-Urgent Referral	Initiate Fitness programming. *Suggested if any single test within a station has follow up recommended or if athlete indicates they exercise < 3 days a week.* Reasons for Recommendation: _____
☐ **Physiotherapist**	◯ Routine Follow-up	*Suggested if currently under care of PT based on subjective reporting at check in.* Continue routine care with a **Physiotherapy** provider at a frequency of: _____
	◯ Non-Urgent Referral	*Suggested if >1 test per station is abnormal with pain, ALL strength tests abnormal with or without pain, TUG or Seated Functional Reach is abnormal, and/or athlete indicates pain at any point during testing.* Reasons for Recommendation: ☐ Flexibility ☐ Strength ☐ Balance ☐ Pain ☐ Other: _____
	Please provide Name/Location of Referral: _____	◯ Provider list dispensed
☐ **Primary Care Provider**	◯ Non-Urgent Referral	*Suggested if an abnormal physiological response to aerobic fitness testing is observed and/or athlete reports 2 or more falls in last 12 months without MD follow-up.* Reasons for Recommendation: _____
	◯ Urgent Referral	Reasons for Recommendation: _____
	Please provide Name/Location of Referral: _____	◯ Provider list dispensed
☐ **Other** **(please specify):** _____	◯ Non-Urgent Referral	Reasons for Recommendation: _____
	◯ Urgent Referral	Reasons for Recommendation: _____
	Please provide Name/Location of Referral: _____	◯ Provider list dispensed