



**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.*

**Station 2: Body Composition**

Screener's Name: _____		
Height: _____ cm	Weight: _____ kg	Waist Measurement: _____ cm
Waist to Height Ratio: _____	BMI (over 20 y.o.): _____	BMI percentile (under 20 y.o.): _____
<i>Unable to test because athlete:</i> Refused to perform      Unable to perform      Unable to understand      Other: _____		
Would you say your health in general is... Excellent      Very Good      Good      Fair      Poor      I don't know      Did not answer		
Have you ever been told by a doctor or other health professional that you have raised blood sugar or diabetes? Yes      No      I don't know      Did not answer If yes, in the past two weeks, have you taken any drugs (medication) for diabetes prescribed by a doctor or other health professional? Yes      No      I don't know      Did not answer Are you following a special diet, exercise regimen, or weight control program for diabetes? Yes      No      I don't know      Did not answer		
About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. Within the past year      Within the past 2 years      Within the past 5 years      More than 5 years ago I don't know      Did not answer		

**Station 3: Bone Density**

Screener's Name: _____	
<i>*Athlete must be at least 20 years old.</i>	
T-Score Zero required before decimal for non-whole numbers (e.g., 0.3). Circle (+) for positive and (-) for negative T-scores.	<b>LEFT:</b> + / - _____
	<b>RIGHT:</b> + / - _____
<i>Unable to test because athlete:</i> Refused to perform      Unable to perform      Unable to understand      Athlete is under 20 years old Other: _____	
Have you ever fractured or broken a bone? Yes      No      I don't know      Did not answer If yes, which bone(s) have you broken? Please describe: _____	



How often do you eat snack foods?					
Daily	Weekly	Monthly	Never	I don't know	Did not answer
How many servings of fruit do you eat on a typical day?					
Never	1 serving	2 servings	3 servings	4 servings	5+ servings
I don't know	Did not answer				
How many servings of vegetables do you eat on a typical day?					
Never	1 serving	2 servings	3 servings	4 servings	5+ servings
I don't know	Did not answer				
How many servings of whole grains do you eat on a typical day?					
Never	1 serving	2 servings	3 servings	4 servings	5+ servings
I don't know	Did not answer				
In the last 12 months did you eat less than you felt like you should because there was not enough money for food?					
Yes	No	I don't know	Did not answer		
Have you received nutritional services for women, infants, and children (e.g., WIC or similar) in the last 12 months?					
Yes	No	I don't know	Did not answer	N/a	
Have you received supplemental nutritional assistance services (e.g., SNAP or similar) in the last 12 months?					
Yes	No	I don't know	Did not answer	N/a	

### **Station 6: Physical Activity**

Screener's Name: _____					
How many days each week do you exercise for at least 30 minutes?					
None	1 day	2 days	3 days	4 days	5 days
6 days	7 days	I don't know	Did not answer		
Do you exercise outside of Special Olympics?					
Yes	No	I don't know	Did not answer		
How many hours do you usually spend sitting each day? (This includes sitting at work, at home, at school, and during your free time. Examples include sitting at a desk, sitting on a bus/train/car, sitting while visiting friends, or sitting or lying down to read, watch television, use a computer/tablet, or phone.)					
<1 hour	1 hour	2 hours	3 hours	4 hours	5 hours
6 hours	7 hours	8 hours	9+ hours	I don't know	Did not answer
What time do you typically go to sleep at night? _____			I don't know	Did not answer	
What time do you typically wake in the morning? _____			I don't know	Did not answer	
On average, how many hours of sleep do you get in a 24-hour period? (Calculate based on time from sleep to wake) _____					
			I don't know	Did not answer	

### Station 7: Sun Safety

Screener's Name:

When you go outside for more than one hour, how often do you protect yourself from the sun?

(Protection from the sun may include using sunscreen, wearing a wide-brimmed hat, or wearing a long-sleeved shirt.)

Always	Most of the time	Sometimes	Rarely	Never	I don't know
Did not answer					

During the past 12 months, how many times have you had a sunburn?

Never	1 time	2 times	3 times	4 times	5+ times
I don't know	Did not answer				

### Station 8: Hand Washing

Screener's Name:

Do you have clean, running water at home?

Yes	No	I don't know	Did not answer
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Do you have soap or hand sanitizer at home?

Yes	No	I don't know	Did not answer
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When are the most important times to wash your hands?

After using the toilet	Before touching food	Other: _____
I don't know	Did not answer	

Do you use soap when washing your hands?

Yes	No	I don't know	Did not answer
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### Station 9: Tobacco Avoidance

Screener's Name:

Do you currently use any tobacco products?

Yes	No	I don't know	Did not answer
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*If yes, which of the following tobacco products do you use?*

Cigarettes	Hookah	Vape	Chew	Snuff	Tobacco pouches	E-Cigarettes	Cigars
Other: _____							

Do you have any friends or family members who smoke near you?

Yes	No	I don't know	Did not answer
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Are you exposed to secondhand smoke at home?

Yes	No	I don't know	Did not answer
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Are you exposed to secondhand smoke in places other than your home?

(Examples include at work, social settings, public areas, etc.)

Yes	No	I don't know	Did not answer
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**Station 10: 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:* \_\_\_\_\_

**Follow-up recommended?**

Yes          No

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

<b>Primary Care Provider</b>	Routine Follow-up	Continue routine care with a <b>Primary Care Provider</b> at a frequency of: _____	
	Non-Urgent Referral	<u>Reasons for Recommendation:</u> BMI                                  Waist to Height Ratio                                  Blood Pressure Bone Density                                  Food Resources                                  Tobacco Cessation	
	Urgent Referral	<u>Reasons for Recommendation:</u> Blood Pressure                                  Bone Density	
	Please provide Name/Location of Referral: _____		Provider list dispensed
<b>Registered Dietitian</b>	Routine Follow-up	Continue routine care with a <b>Registered Dietitian</b> at a frequency of: _____	
	Non-Urgent Referral	<u>Reasons for Recommendation:</u> BMI                                  Waist to Height Ratio                                  Food Resources	
	Please provide Name/Location of Referral: _____		Provider list dispensed
<b>Fitness Programming</b>	Routine Follow-up	Continue with current SO Fitness program. <i>Suggested if currently participating in local fitness programming</i>	
	Non-Urgent Referral	Initiate Fitness programming. <i>Suggested if athlete indicates they exercise &lt; 3 days a week</i> Reasons for Recommendation: _____	
<b>Other</b> <b>(please specify):</b> _____	Non-Urgent Referral	<u>Reasons for Recommendation:</u> _____	
	Urgent Referral	<u>Reasons for Recommendation:</u> _____	
	Please provide Name/Location of Referral: _____		Provider list dispensed