Firstname	**Lastname**	**HAS ID** ____ ____ _____ ____ ____

Date	**O Male O Female**	**DoB**	**Age (years) O Not sure**
Event	Location	O Athlete O Unified partner	Sport
Delegation		SO Program	
Cell phone number		**Number is O Athlete's O 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.			

Body Composition

Height ____ _•___ cm
Measure up to 0.1 cm

Height _____ inches
Measure up to 1/8 inch

Weight _____•___ kg
Measure up 0.1 kg

Weight _____ lbs. ____ oz.
Measure up to ½ oz

_____ **BMI** (20 years of age and over)

_____ **BMI** Percentile (under 20 years of age)

Referral made for BMI follow Up? O Yes O No

Bone Mineral Density Test (Athletes MUST be at least 20 years old to screen)

T-score Left heel ____•__ *-4.0 to + 5.0*

Right heel ____•__ *-4.0 to + 5.0*

☐ Unable to test
- ☐ Age under 20
- ☐ Athlete refused
- ☐ Athlete unable to cooperate
- ☐ Unusual heel shape

Referral made for BMD follow Up? O Yes O No

Blood Pressure

Right arm _____/_____

Left Arm _____/_____

Referral made for BP follow Up? O Yes O No

Nutrition – Food and Beverage Habits

What do you usually drink when you are thirsty? (select all that apply)

☐ Water
☐ Fruit juice
☐ Soft drink O Diet O non diet
☐ Sports drink
☐ Milk product (includes soy)
☐ Energy drink
☐ Other

Sources of Calcium O less than 1 serving per day O 1-2 servings per day O 3-5 servings per day O more than 5 servings per day O never	**Sweetened Beverages** O daily O weekly O monthly O never
Fruits and Vegetables O less than 1 serving per day O 1-2 servings per day O 3-5 servings per day O more than 5 servings per day O never	Snack Foods O daily O weekly O monthly O never
Fast food O daily O weekly O monthly **O** never	

Firstname	Lastname	HAS ID ____ ____ _____ ____ ____

Physical Activity

How many days per week do you exercise for at least 30 minutes?
O No days O 1-2 days O 3-6 days O Every day

Do you exercise outside of your Special Olympics training? O Yes O No
If yes, what do you do? (select all that apply)
☐ Weight training ☐ Run/Jog ☐ Walk ☐ Dance ☐ Sports ☐ Exercise video
☐ Other

If No, what is the reason? (select all that apply)
☐ No interest ☐ No money
☐ Do not know how ☐ Physically unable
☐ No transportation ☐ No one to do it with
☐ No available exercise facility ☐ No time
☐ Other

How many hours a day do you watch television or play computer/video games?
O 0-2 O 3-4 O 5-6 O Over 6 hours

Hand Washing

When are the most important times to wash your hands? (select all that apply)
☐ After using the toilet ☐ Other reason
☐ Before eating or touching food ☐ No response/no reasons given

Did you use soap last time you washed your hands?
O Yes O No

Do you have soap at your home?
O Yes O No

Sun Safety

Do you do anything to protect your skin in the sun?
O Yes O No

If yes, what do you do to protect your skin in the sun? (select all that apply)
☐ use sunscreen ☐ wear a hat
☐ seek shade ☐ wear sunglasses
☐ wear long sleeves ☐ I do not do anything

If no, what is the reason? (select all that apply)
☐ Did not know it was important ☐ No money to buy protection
☐ Do not get sunburned ☐ Like to be tan
☐ Other

Tobacco Use

Do you use tobacco? O Yes O No
If yes, how frequently? O daily O weekly O monthly

Do any of your friends or family members smoke near you? O Yes O No
If yes, what do you do when they are smoking near you? (select all that apply)
☐ Ask them to stop ☐ Leave the room ☐ Smoke ☐ I do not do anything
☐ Other