First Name	**Lastname**	**HAS ID** _____ _____ ______ _____ _____

Date:	**Male** **Female**	**DoB:**	**Age:** **(years)** **Not sure**
Event:	Location:	Athlete Unified partner	Sport:
Delegation:		SO Program:	
Cell phone number		**Number is:** **Athlete's** **Parent's / Guardian 's**	
Providing a phone number is optional. It may be used to call or send reminders if 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? Yes No O Urgent O Not Urgent

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? Yes No O Urgent O Not Urgent

Blood Pressure

Right arm ________/_______

Left Arm ________/_______

Referral made for BP follow Up? Yes No O Urgent O Not Urgent

Nutrition – Food and Beverage Habits

Do you take vitamin D supplements? Yes No Don't know

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

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

Other

Calcium Foods and Beverages 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	**Fast food** 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	

First Name	Lastname	HAS ID _____ _____ ______ _____ _____

Physical Activity

How many days each week do you exercise for at least 30 minutes?

no days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

Do you exercise outside of your Special Olympics training? Yes No

If yes, what do you do? (Select all that apply)

Weights Run/Jog Walk Dance Sports Exercise DVD, Wii Job Other

If no, what is the reason? (Select all that apply)

- ☐ No interest
- ☐ Do not know how
- ☐ No transportation
- ☐ No money
- ☐ Physically unable
- ☐ No one to do it with
- ☐ No time
- No place to exercise
- Other

How many hours a day do you watch television or play computer/video games?

0 hours 1—2 hours 3-4 hours ☐ 5-6 hours Over 6 hours

Hand Washing

When are the most important times to wash your hands? (select all that apply)

☐ After using the toilet ☐ Before eating or touching food ☐ other reason ☐ No reasons given

Did you use soap when last washing your hands? Yes No **Do you have soap at home?** Yes No

Sun Safety

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

If yes, what do you do to protect your skin in the sun? (select all that apply)

☐ use sunscreen ☐ wear a hat ☐ wear long sleeves ☐ seek shade ☐ wear sunglasses ☐ I do nothing

If no, what is the reason? (select all that apply)

- ☐ Did not know it was important
- ☐ Don't get sunburned
- ☐ No money to buy protection
- ☐ Like to be tan
- Other

Tobacco Use

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

Do any of your friends or family members smoke near you? Yes 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

Check out: Follow up care recommended?

BMI	Yes	No	O Urgent	O Not Urgent
BMD	Yes	No	O Urgent	O Not Urgent
BP	Yes	No	O Urgent	O Not Urgent