**HEALTHY YOUNG ATHLETES PEDIATRIC SCREENING**

**Part 1: Pre- Screening Form**

***To be completed by a parent or guardian before screening event***

Dear Parent or Guardian,

You have received this pre-screening document to complete as part of your participation in the Healthy Young Athletes Pediatric Screening. The Healthy Young Athletes Pediatric Screening is meant to support the health care and developmental needs of your child. This screening will provide information, tools, and direct referrals to local community healthcare and related providers and services. This is intended to enhance, not replace, existing support and services with which you are already engaged.

This screening and consultation are part of the [Special Olympics Young Athletes](https://www.specialolympics.org/our-work/inclusive-health/young-athletes) program. Whether your child has been participating in Young Athletes on a regular basis or this is your first time at a Special Olympics event, we thank you for completing the information in this pre-screening.

Once the pre-screening questionnaire is complete, your information will be shared with a designated clinical director at your local Special Olympics Program. At the Healthy Young Athletes Pediatric Screening, you and your child will receive a comprehensive screening and consultation to address any areas of need or gaps in care and development. As a result of the screening, your child may receive a referral for follow-up care with a local provider or specialist. Many families will also receive additional educational information to support the ongoing health and development of their child.

Your answers to the pre-screening will help us to explore ways to promote your child and family’s strengths, as well as to identify potential areas of need prior to the screening and consultation event. This screening tool was developed to journey with you in providing the best for your child.

Answers to questions in the pre-screening and at the screening and consultation event are all optional. Share information you feel comfortable with and if you are not sure about how to answer a question, leave that space blank. The Special Olympics staff or volunteer seeing you during the face-to-face screening and consultation will review any confusing questions with you, as well as any areas that require more discussion.

Special Olympics welcomes you as you embark on this deep dive into the health and wellbeing needs of your child. Every child deserves the attention, support, and services of qualified healthcare professionals. It is our goal to work with you as you navigate the system and provide ongoing support, so your child lives a long healthy active life.

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| ***Consent to Participate*** | | |
| Special Olympics offers certain non-invasive health care services to athletes at local, state, national, and World Games venues through the Healthy Athletes® Program. These services may include individual assessments of health status and health care needs, provision of health education, routine preventive services (e.g. protective mouth guards), educational services, and, in the case of vision and hearing deficits, provision of needed eyewear (glasses, swim goggles, protective eyewear) and hearing aids. Athletes are informed as to their health status and advised of the need for follow-up care. In addition, information collected at the time that services are provided has been invaluable for developing policies, securing resources, and implementing programs to better meet the health needs of athletes.  **Authorization for Minors**: I understand that by signing below I consent to \_\_\_Click or tap here to enter text.\_­­­(athlete’s full name) participation in the Special Olympics Healthy Athletes Pediatric Screening program provides individual screening assessments of general pediatric health. I understand there is no obligation for the athlete named above to participate in the Healthy Athletes Program should the athlete decide not to participate or should I decide the athlete shall not participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services for the athlete named above and that Special Olympics is not through the provision of these provisions responsible for the health of the athlete named above. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. | | |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Parent or Guardian Signature | Special Olympics Program | Date |

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| ***Background Information About Your Child*** | | | | | | | | | | |
| Name of Child | Click or tap here to enter text. | | | | Child’s Date of Birth | | | Click or tap here to enter text. | | |
| Name of Parent | Click or tap here to enter text. | | | | SO Program Location  *(State or Country)* | | | Click or tap here to enter text. | | |
| Parent Email | Click or tap here to enter text. | | | | Parent Phone Number | | | Click or tap here to enter text. | | |
| Language Spoken at Home | Click or tap here to enter text. | | | | Needs Wheelchair accessible location for in-person events | | | | | |  | | --- | |  |   YES NO |
| **1. What are your child’s greatest strengths?** *Please check all that apply.* | | | Independent | | | Playful | | | Happy | |
| Social | | | Patient | | | Calm | |
| *Provide more details in the space below*:  Click or tap here to enter text. | | | | | | | |
| **2. Please list some fun facts about your child.**  *(e.g. what activities/places/animals make them happy, what soothes them, what is their favorite toy, character etc.)* | | | | Click or tap here to enter text. | | | | | | |
| **3. What aspects of your child’s health and development are you most concerned about?**  *Please check all that apply.* | | Tantrums, emotional regulation, behavioral issues | | | | Suspected medical illness | | | Language or communication | |
| Adaptive skills (toilet training, self-grooming) | | | | Nutrition, feeding or weight | | | Social skills | |
| Hearing | | | | Dental health | | | Vision | |
| Sleep patterns or habits | | | | Other | Click or tap here to enter text. | | | |
| **4. My child is currently being assessed for the following medical, developmental, behavioral and/or emotional concerns.** | | | Click or tap here to enter text. | | | | | | | |

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| ***Child’s Health Care History*** | | | | | | | | |
| **5. When was the *last time* your child had the following?** *Please check all that apply* | | | | | | | | |
|  | | *Within 1 month* | *Within 1 year* | | *Too long to remember* | | | *Never* |
| Well child check-up/regular physical | |  |  | |  | | |  |
| Hearing test, type:Click or tap here to enter text.  Normal or  Abnormal | |  |  | |  | | |  |
| Vision test  Normal or  Abnormal | |  |  | |  | | |  |
| My child is up to date on CDC/WHO recommended childhood vaccines.  *Please bring your vaccine records to pediatric screening event* | | | | | | | Yes | No |
| **6. What types of therapies or additional support does your child currently have?**  *Please check all that apply.* | Individual Educational Plan (IEP)/ 504 school education plan | | | | Early intervention/ Early Start services | | | |
| Physical therapy | | | Occupational therapy | | Feeding therapy | | |
| Special School/ Therapeutic School | | | Speech/ language therapy | | Dietitian/ nutrition | | |
| Developmental/ Behavioral therapy | | | Other | Click or tap here to enter text. | | | |

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| ***Child’s Medical History*** | | |
| **7. Has your child ever been diagnosed with any of the following conditions?** *Please check all that apply.* | | |
| *Medical Illness*  Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No | *Dental*  Cavities  Gum Infection | *Ears & Hearing*  Hearing Loss  Repeat ear infections |
| *Eyes & Vision*  Wandering/lazy eye  Problems seeing  Blindness (including legal  blindness) | *Genetic Syndrome*  Down Syndrome  Fragile X Syndrome  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | *Neurologic Conditions*  Cerebral Palsy  Traumatic brain injury or bleed  Stroke (low oxygen, blood flow, or clot to brain)  Meningitis or other brain infection  Hydrocephalus (fluid build-up in the brain)  Seizures / Epilepsy |
| Other conditions not listed above: \_\_\_\_\_\_\_\_\_\_\_Click or tap here to enter text.\_\_\_\_ | | |

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| ***Child’s Developmental, Behavioral & Emotional History*** | | |
| **8. Are you concerned/have you ever been told that your child has any of the following?** *Check all that apply.* | | |
| *Developmental Delays*  Delay in speech/ language/ communication  Delay in fine motor skills (use of fingers and hands)  Delay in gross motor skills (large movements to get to  places)  Delay in problem-solving, thinking, reasoning.  Delay in social-emotional skills. | *Developmental Diagnoses*  Autism/ Autism Spectrum Disorders (ASD)  Fetal Alcohol Syndrome (FAS)  Global developmental delays  Intellectual Disability (ID)  Learning Disability  Attention Deficit Hyperactivity Disorder (ADHD) | |
| *Mental Health Diagnoses*  Anxiety  Depression | | |
| Other conditions not listed above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **9. Do you worry that your child is being bullied by other children or adults?**  *This includes both verbal and physical aggression.* | | Yes No |

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| ***Environment, Safety and Resources*** | | | | |
| *This next section includes standard questions recommended by pediatric experts at all health visits. All these social and environmental issues can affect health and development. Your family will be offered resources if any needs are found.* ***Feel free to skip over any questions you prefer not to answer.*** | | | | |
| **10. Please check all that apply.** | In the last 12 months, I (parent) or my child ate less than I felt I/we should because there wasn’t enough money for food. | | Do you currently use/have access to a food support program?  Yes or  No | |
| I am worried that in the next 3 months, I may not have stable housing. | | In the last 12 months, the electric, gas, oil, or water company has threatened to shut off services to my home. | |
| In the last 12 months, transportation problems caused someone in my household to miss needed healthcare. | | My child lives in, or regularly visits, a home built before 1978 (a home that increases their exposure risk to lead). | |
| My child lives with someone who smokes or vapes (e.g. cigarettes, e-cigarettes, jules, pot, cannabis). | | None of the above | |
| **11. What has been your experience with medical insurance for your child?** *Please check all that apply* | | In the last 12 months, I felt that my child needed to see a doctor but could not do so due to cost. | | I have had difficulty obtaining insurance coverage for my child. |
| My insurance does not provide adequate coverage for my child’s needs. | | None of the above |

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| ***Current or Ongoing Behavioral Concerns*** | | | |
| ***Does your child…*** | ***Never*** | ***Sometimes*** | ***Often*** |
| **12. Cry, scream, tantrum for unusually long periods of time, or have difficulty calming down?** |  |  |  |
| **13. Have difficulty sitting still, is fidgety, or trouble paying attention?** |  |  |  |
| **14. Try to hurt himself/herself?** *(For example, by head banging, biting, skin picking)* |  |  |  |
| **15. Try to hurt other people or animals?** *(For example by kicking, biting, pinching)* |  |  |  |
| **16. Seem unusually worried or nervous compared to other children his or her age?** |  |  |  |
| **17. Wander away from you or other adults in charge?** |  |  |  |
| **18. Have a hard time with change, new people, or new places?** |  |  |  |
| **19. Seem uninterested in playing with other children?** |  |  |  |
| **20. Have unusual sensory needs?** *(e.g. Cannot handle loud noises, or doesn’t like the feeling or certain clothing textures, or must constantly spin or bump into things, etc.)* |  |  |  |
| **21. Frequently appear sad or says he/she is sad** |  |  |  |
| **22. Pretend play about scary or sad things** |  |  |  |
| **23. Blame himself/herself for things** |  |  |  |
| **24. Often seem to be tired and has very low energy** |  |  |  |
| ***Is it hard to…*** | ***Never*** | ***Sometimes*** | ***Often*** |
| **21. Understand what your child wants/needs when they are crying/upset?** |  |  |  |
| **22. Take your child out in public due to concern about other people’s perception/reaction to your child’s appearance/behavior?** |  |  |  |

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| ***Child’s Physician and Insurance Information*** |

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| **Physician Name:** |  |
| **Physician Phone Number:** |  |
| **Insurance Name:** |  |
| **Insurance Policy Number:** |  |
| **Insurance Group Number:** |  |