

SECTION A - ATHLETE HEALTH INFORMATION

AREA PROGRAM: _____ Sex/Gender _____

Athlete Name _____ Date of Birth (month, day, year) ____/____/____

Address _____ Home Phone (____) ____-____

_____ Email Address _____

Parent/Guardian Name _____ Home Phone (____) ____-____

Address (If different from athlete.) _____ Work Phone (____) ____-____

_____ Email Address _____

Emergency Contact (If other than parent/guardian.) _____ Home Phone (____) ____-____

_____ Cell Phone (____) ____-____

Health/Accident Company _____ Policy # _____

1. Heart Disease/Heart Defect/High Blood Pressure	Yes ___ No ___	13. Impaired motor ability	Yes ___ No ___
2. Chest Pain or Fainting Spells	Yes ___ No ___	14. Uses a wheelchair	Yes ___ No ___
3. Seizure/Epilepsy	Yes ___ No ___	15. Allergy to the following (list specific)	Yes ___ No ___
4. Diabetes	Yes ___ No ___	Medicine _____	
5. Down Syndrome	Yes ___ No ___	Food _____	
Have cervical spine(neck bone) X-rays been done	Yes ___ No ___	Insect Sting/Bite _____	
Presence of Atlanto Axial Instability	Yes ___ No ___	16. Special diet	Yes ___ No ___
6. Parent/Sibling (under 40) died of heart disease	Yes ___ No ___	17. Exercise induced wheezing	Yes ___ No ___
7. Absence of vision/blind in one eye	Yes ___ No ___	18. Tendency to bleed easily	Yes ___ No ___
8. Absence of one kidney or testicle	Yes ___ No ___	19. Emotional/psychiatric/behavioral problems	Yes ___ No ___
9. Concussion of serious head injury	Yes ___ No ___	20. Serious bone of joint disorder	Yes ___ No ___
10. Major surgery or serious illness	Yes ___ No ___	21. Sickle cell trait or disease	Yes ___ No ___
11. Heat stroke/exhaustion	Yes ___ No ___	22. Hearing aid/hearing loss	Yes ___ No ___
12. Other problem that would interfere with sports participation...List _____	Yes ___ No ___	23. Contact lenses/eye glasses	Yes ___ No ___
		24. Dentures/ false teeth	Yes ___ No ___
		25. Immunizations (shots) are up-to-date	Yes ___ No ___
		26. Date of last tetanus shot:	
		_____/_____/____	

Athletes must have a physical examination every three (3) years performed by a physician or a licensed examiner or nurse practitioner working under the supervision of a physician.

SECTION B - MEDICAL CERTIFICATION AND SIGNATURE

EXAMINER'S NOTE: If the athlete has Down Syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-Axial Instability before he/she may participate in sports or events which, by their nature may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which a radiological examination is required are: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football team competition (soccer).

[] I have reviewed the above health information on and examined the athlete named in the application, and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

RESTRICTIONS _____

EXAMINER'S SIGNATURE _____ **DATE** _____

EXAMINER'S NAME _____

ADDRESS _____

CITY _____ **TN** _____ **ZIP** _____ **PHONE** (____) ____-____

SECTION C - COMMENTS, MEDICATIONS, PARENT/GUARDIAN/ATHLETE SIGNATURE

Comments _____

MEDICATIONS-Please print medication name, amount, date prescribed and number of times per day medication needs to be taken

Person completing form (normally parent/guardian or adult athlete) Signature _____ Date _____

If Health Information Section A is completed by adult athlete-I have reviewed the health history with the athlete whose signature appears above.

Signature _____ **Date** _____ **Relationship to athlete** _____

IMPORTANT: If at anytime there is any significant change in the athlete's health, the athlete's condition should be reviewed by a licensed examiner before further participation.