Athlete Medical Form

Special Olympics Wisconsin

To be completed by Special Olympics

REGION: ☐ MedFest® ☐ Individual Physical

DELEGATION: ☐ Unified Partner (Medicals Optional) ☐ Healthy Young Athletes

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date of Birth (dd/mm/yyyy) Female: ☐ Male: ☐

Mailing Address:

Phone: Cell:

E-mail: Eye Color:

I am my own guardian. ☐ Yes ☐ No

☐PARENT ☐GUARDIAN INFORMATION

Name:

Phone: Cell:

E-mail:

Athlete's Primary Care Physician:

Phone:

Insurance Provider:

Policy Number:

Does the athlete have (check any that apply):

☐ Autism ☐ Down syndrome ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome

☐ *Other syndrome, please specify:*

List any sports the athlete wishes to play:

Is the athlete allergic to any of the following (please list):

☐ Food:

☐ Medications:

☐ Insect Bites or Stings:

☐ Latex ☐ No Known Allergies

Does the athlete use (check any that apply):

☐ Dentures ☐ Communication Device ☐ Wheel Chair

☐ Brace ☐ Removable Prosthetics ☐ Crutches or Walker

☐ Splint ☐ Glasses or Contacts ☐ Hearing Aid

☐ Pacemaker ☐ G-Tube or J-Tube ☐ Implanted Device

☐ Inhaler ☐ Colostomy ☐ C-PAP Machine

List all past surgeries:

List any special dietary needs:

List all ongoing or past medical conditions:

List all medical conditions that run in the athlete's family:

Does the athlete have any religious objections to medical treatment?

☐ No ☐ Yes *If yes, please complete the religious objections form.*

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes

Has any family member or relative died while exercising? ☐ No ☐ Yes

Does the athlete currently have any chronic or acute infection?

☐ No ☐ Yes

Has the athlete ever had an abnormal Electrocardiogram (EKG)?

☐ No ☐ Yes

Has a doctor ever limited the athlete's participation in sports?

☐ No ☐ Yes

Has the athlete ever had an abnormal Echocardiogram (Echo)?

☐ No ☐ Yes

Has the athlete had a Tetanus vaccine within the past 7 years? ☐ No ☐ Yes

Athlete's Name _____

PLEASE INDICATE IF THE ATHLETE HAS EVER HAD ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Stroke / TIA	☐ No	☐ Yes
Dizziness during or after exercise	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	Concussions	☐ No	☐ Yes
Headache during or after exercise	☐ No	☐ Yes	Vision Impairment	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Chest pain during or after exercise	☐ No	☐ Yes	Hearing Impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Shortness of breath during or after exercise	☐ No	☐ Yes	Enlarged Spleen	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Irregular, racing or skipped heart beats	☐ No	☐ Yes	Single Kidney	☐ No	☐ Yes	Urinary Discomfort	☐ No	☐ Yes
Congenital Heart Defect	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes	Spina Bifida	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes	Osteopenia	☐ No	☐ Yes	Arthiritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait Easy	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Bleeding	☐ No	☐ Yes			
Endocarditis	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ Yes			

Any difficulty controlling bowels or bladder ☐ No ☐ Yes

If Yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Numbness or tingling in legs, arms, hands or feet ☐ No ☐ Yes

If Yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Weakness in legs, arms, hands or feet ☐ No ☐ Yes

If Yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet ☐ No ☐ Yes

If Yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Head Tilt ☐ No ☐ Yes

If Yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Spasticity ☐ No ☐ Yes

If Yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Paralysis ☐ No ☐ Yes

If Yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Please describe any past broken bones or dislocated joints:

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

If Yes, list seizure type:

Seizure during the past year? ☐ No ☐ Yes

Self-injurious behavior during the past year ☐ No ☐ Yes

Aggressive behavior during the past year ☐ No ☐ Yes

Depression ☐ No ☐ Yes

Anxiety ☐ No ☐ Yes

Please describe any additional mental health concerns:

Ethnicity:

Is the Athlete Employed? If yes, list employer ☐ No ☐ Yes

PLEASE LIST ANY MEDICATIONS, VITAMINS OR DIETARY SUPPLEMENTS BELOW *(include inhalers, birth control or hormone therapy)*

Medication, Vitamin, or Supplement	Dosage	Times Per Day	Medication, Vitamin, or Supplement	Dosage	Times Per Day	Medication, Vitamin, or Supplement	Dosage	Times Per Day

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

If female, list the date of the athlete's last menstrual period:

Athlete Signature *(if own guardian)* Date

Legal Guardian Signature *(only if not own guardian)* Date