Indy Stars Gymnastics Medical Form Instructions

The Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program is divided into two sections. The athlete section (the first three pages) asks for general information about the athlete, their medical history and a Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program official release. This section must be completed and signed prior to the athlete seeing a physician for a pre-participation sports physical and should be filled out by the person (or people) who can give the most complete and accurate account of the athlete's medical history. **The medical section (pages 4 & 5) must be completed and signed by a physician or other licensed healthcare personnel such as nurse practitioners or physician assistants**. It is required that all athletes must complete a medical form prior to participation. Furthermore it is required that all Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program athletes update their medical form completely every three years, if not more frequently. **No outside agency or school physical forms will be accepted.**

Page 1 - Athlete Section (To be completed by the Athlete, Parent or Guardian)

1) **Athlete Information –** List the athlete's name, date of birth, gender, home address, contact phone numbers, email address, eye color, and legal guardianship status.

2) **Physician Information –** List the name, phone number and address of the athlete's primary care physician. This may be different from the name of the physician that performs the pre-participation physical.

3) **Syndrome Information –** State if the athlete has Autism, Cerebral Palsy, Down Syndrome, Fragile X Syndrome and/or Fetal Alcohol Syndrome. If the athlete has any other syndrome or condition that caused the athlete's intellectual disability, please list it in the box marked "other syndrome".

4) **Sports –** List any sports that the athlete is interested in playing.

5) **Allergies –** Specify any food, medication, insect or latex allergies that the athlete may have. If the athlete has no allergies, mark "No Known Allergies".

6) **Assistive Devices –** Specify if the athlete uses any assistive devices such as: dentures, a brace, splint, pacemaker, communication device, removable prosthetic, glasses or contacts, G-tube or J-tube, colostomy bag, wheel chair, crutches or walker, hearing aid, implanted device or C-PAP machine.

7) **Surgical History** – List any past surgeries that the athlete has had and why the athlete had the surgery.

8) **Special Dietary Needs** – List any dietary needs that the athlete has, for example: gluten free diet, vegetarian, vegan, lactose free, peanut free, or any religious diet preferences**.**

9) **Medical History –** List all past or ongoing medical conditions for which the athlete required or currently requires treatment.

10) **Family History** – List any conditions that run in the athlete's family. It is especially important to note any genetic, neurological or cardiac conditions.

11) **Religious Objections** – If the athlete finds himself or herself in a medical emergency, are there any medical treatments (such as blood transfusions) which should not be given to the athlete based on his or her religion? Please specify.

12) **Cardiac History** – Specify if the athlete has ever had a close relative (parent, grandparent, aunt, uncle, brother, sister or cousin) die from heart problems before the age of 40 or while they were exercising. Specify if the athlete has ever had an abnormal electrocardiogram (EKG, ECG) or echocardiogram (echo). If yes, circle which test (EKG or echocardiogram) and please describe what cardiac abnormality was found.

13) **Active Infection** – If the athlete has ANY acute infection (including minor infections such as a cold or flu), or if the athlete has any chronic bacterial or viral infection, please describe the nature of the infection.

14) **Previous Limitations** – Note if any doctor has ever prohibited the athlete from participating in sports for any medical reason. If so, specify the reason.

15) **Tetanus Vaccine** – Specify if the athlete has had a tetanus (sometimes called a DTaP or DTP vaccine) within the past 7 years. If not, the athlete may be required to obtain a tetanus vaccine prior to participation.

16) **Parent/Guardian Information –** If the athlete is not his or her own guardian, please list the name, phone numbers and email address of the person who makes legal and medical decisions for the athlete. Specify if that person is the athlete's parent or legal guardian.

Page 2 - Athlete Section (To be completed by the Athlete, Parent or Guardian)

18) **Specific Medical Conditions** – Check any or all medical conditions that the athlete currently has or has had in the past.

19) **Possible Neurological Symptoms** – Specify if the athlete has incontinence or any numbness, weakness, pain or discomfort, head tilt, spasticity or paralysis of any part of the body. If any of these symptoms are present, it is important to state whether any of these symptoms are new or have gotten worse within the past 3 years.

20) **Broken Bone or Dislocated Joints –** List any that the athlete has had in his or her life.

21) **Seizures –** Specify if the athlete has a seizure disorder and, if so, what kind of seizures (if known) and whether the athlete has had one or more seizures within the past year.

22) **Mental Health –** Note if the athlete has had any self-injurious or aggressive behaviors (such as hitting others) within the past year. Also note if the athlete has depression or anxiety. List any other mental health concerns such as AD/HD, schizophrenia, bipolar, psychosis, etc., that the athlete has currently or has had in the past.

23) **Medications –** List all of the athlete's current medications including: prescription drugs, over the counter medications, vitamins, herbal supplements, inhalers, birth control pills (or shots) or hormone therapy.

24) **Self-Administration** – Specify if the athlete is able to administer his or her medications reliably and consistently, without assistance or reminders.

25) **Menstrual History** – If the athlete is female, specify the date of the athlete's last menstrual period. If the exact date is unknown specify approximately how long it has been since the athlete had her period.

26) **Signatures and Date** – ***Sign in the highlighted yellow area.*** If the athlete has a legal guardian (often a parent), then the legal guardian or parent must sign and date the medical form. If the athlete is his or her own legal guardian, then he or she must sign and date the medical form. Both signatures are encouraged though not required, as long as the legally responsible party has signed.

Page 3 - Athlete Sections (To be completed by the Athlete, Parent or Guardian)

27) **Athlete Release Form –** Page 3 (to be completed and signed by adult athlete 18 years of age or older or parent/guardian of minor athlete) consists of Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program Official Release to participate in Special Olympics, permission to use athletes likeness, name, voice and words in any type of media, permission to participate in Healthy Athletes, and permission to treat in case of an emergency. ***Sign in the highlighted yellow area.***

Page 4 - Medical Section (To be Completed by Physician or Other Licensed Provider)

28) **Height –** Measured in inches.

29) **Weight –** Measured in pounds.

30) **Temperature –** Measured in Fahrenheit. Increased temperature may indicate an acute infection that may place the athlete at risk during sports participation.

31) **Pulse –** Measured in beats per minute. Extraordinarily high or low pulse rates may be associated with medical issues that may place the athlete at additional risk during sports participation.

32) **O_2 Sat. –** Blood oxygen saturation percent, as measured by a pulse oximeter at room air. Decreased blood oxygenation may be an indication of significant cardiac or pulmonary abnormalities that may place the athlete at risk during sports participation.

33) **Blood Pressure –** Measured in mmHg. First, measure blood pressure in the right arm of a calm and rested athlete. If the blood pressure is hypertensive (greater than 140/90) then measure the blood pressure in the left arm to confirm. If the blood pressure in the right arm is normal, measuring the blood pressure in the left arm is not necessary. A difference between right and left blood pressures of more than 20 mmHg may indicate an aortic anomaly that may place the athlete at risk during sports participation. Significant hypertension (stage II hypertension in children or adults) may place the athlete at additional risk during sports participation.

34) **Vision –** Test the athlete's ability to read the 20/40 line only on a distance vision chart (Lea chart is preferred) with each eye covered separately. If the athlete's vision cannot be determined for a specific eye, mark "N/A".

35) **Physical Exam** – The physical exam performed on the athlete should be thorough. The examiner should pay close attention to any signs or symptoms of cardiopulmonary or neurological conditions – especially new or changing neurological conditions. Documentation of the physical exam is absolutely necessary. Additional physical findings not described on the form may be noted in a subsequent section below. Note that in the MedFest environment, genitourinary, breast and rectal examinations are not performed, however these portions of the physical exam may be performed in an "individual exam" according to the preference of the examiner. *Examiner's Tip: The first column of responses to the different parameters of the physical exam represent what would traditionally be called the "within normal limits" response. Drawing a straight line down this column on both sides signifies that the physical exam was completely normal and unremarkable.*

36) **Spinal Cord Compression or Atlantoaxial Instability –** The medical history form asks a series of questions about possible neurological symptoms that could be associated spinal cord compression and/or atlantoaxial instability. The physical exam form asks the examiner to assess for signs of possible spinal cord compression and/or atlantoaxial instability. The presence of any signs or symptoms should be taken seriously, as the presence of spinal cord compression and/or atlantoaxial instability is associated with significant risk of spinal cord injury in the sports environment. Athletes who describe incontinence or any numbness, weakness, pain or discomfort, head tilt, spasticity or paralysis of any part of the body, especially if any of those symptoms are new or have worsened within the past 3 years may need additional neurological evaluation before they can be cleared to participate in any Special Olympics sports. Likewise, abnormal reflexes, gait, spasticity, tremors, changes in mobility, strength or sensitivity may also suggest that an athlete needs additional neurological evaluation. It should be noted that not all neurological signs and symptoms (such as those that are stable and long-standing) will require further neurological evaluation.

In this section, the examiner must specify if there are any signs or symptoms that could be associated with spinal cord compression and/or atlantoaxial instability. If so, the athlete may not be cleared for sports participation until they have been seen by a neurologist, neurosurgeon or other physician qualified to determine, definitively, if participation in sports activity, in the presence of the noted neurological signs and symptoms, will be safe for the athlete.

37) **Recommendations** – Specify if the athlete is able (medically safe) to participate in Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Programor not.

Generally, clearance for sports is an all-or-none phenomenon. However, in some cases the physician may opt to clear the athlete for some sports or for all sports with some limitations. For example, an athlete who has had seizures within the past year may be cleared with the recommendation to not participate in certain higher risk sports for people with seizures, such as swimming, sailing, bicycling, downhill skiing, or equestrian events. Athletes with acute infections may be cleared to participate once the infection has been adequately treated.If an athlete is not cleared for sports participation, a reason must be given. The most common reasons for not clearing an athlete for participation are noted (concerning cardiac exam, concerning neurological exam, acute infection, stage II hypertension or higher, oxygen saturations of less than 90%, hepatomegaly or splenomegaly). If the athlete is not cleared for another reason, please describe the reason in the open box provided.

38) **Additional Examiner Notes –** The examiner may write any other information the examiner wishes to provide including additional instructions, restrictions, limitations, examinations performed or not performed or other pertinent information.

39) **Referrals –** Whether or not the athlete is cleared for sports participation, the examiner may wish to refer the athlete to another medical professional for additional evaluation. The most common specialists to refer to (cardiologist, neurologist, primary care physician, vision specialist, hearing specialist, dentist or dental hygienist, podiatrist, physical therapist or nutritionist) are provided in this section. Other referrals may be handwritten in the "Other" box.

40) **Examiner's Signature and Information –** ***Sign in the highlighted yellow area.*** The physician or other licensed healthcare provider performing the exam and providing medical clearance for the athlete must sign the bottom of page 3. Additionally, they should fill in the date of the exam, print their name, as well as put their email address, phone number and medical license number.

Page 5 - Additional Medical Page (To be completed by Additional Physicians)

41) **Further Medical Evaluation –** Page 5 consists of four separate further medical evaluation forms. These forms are only to be used if the athlete has been examined first by a physician and, through the course of the sports physical, was denied sports clearance based on the need for further medical evaluation. If only one additional medical examination is needed for clearance, only one quadrant of page 4 must be completed by the physician who is doing the additional medical evaluation. To complete this form (and thus to complete the medical clearance process), the additional physician must print his or her name and medical specialty, state the purpose for the referral and state whether or not the athlete may participate in sports after the assessment of the athlete. Additional notes, restrictions, qualifying comments or referrals may be entered in the space for "additional examiner notes". Finally, the additional examining physician should list his or her email address, phone number, license number as well as sign and date the referral form.

Athlete Medical-Release Form Guidelines

Anyone participating in a Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program must have a Medical-Release form on file at the state office before the practice/event.

Participants are required to complete a Medical-Release form every three (3) years.

Please fill out the form completely! It is extremely important that you provide the most comprehensive information possible so Indy Stars Gymnastics can provide the greatest assistance and care to each athlete and make sure that each Special Olympics event is enjoyable and safe.

ELIGIBILITY STATEMENT

- To be able to participate in Indy Stars Gymnastics Adaptive Gymnastics Program the participant must be 5-7 years old and for the Special Olympics Program the participant must be 8 years or older and:
- have a cognitive delay (learn slower than their peers) as determined by standardized measures; or
- have significant learning or vocational problems** due to cognitive delays which require or have required specially-designed instruction***.

**Significant learning or vocational problems refer to those learning problems resulting from cognitive delays (intellectual impairment). These do not include physical disability, emotional or behavioral difficulties or specific disabilities such as dyslexia or speech or language impairment.

***Specially-designed instruction refers to time when a person is receiving supportive education or remedial instruction directed at the cognitive delay. In the case of adults, specially-designed instruction is usually replaced with specially-designed programs in the workplace, or in the support work place, or in supported work or at home.

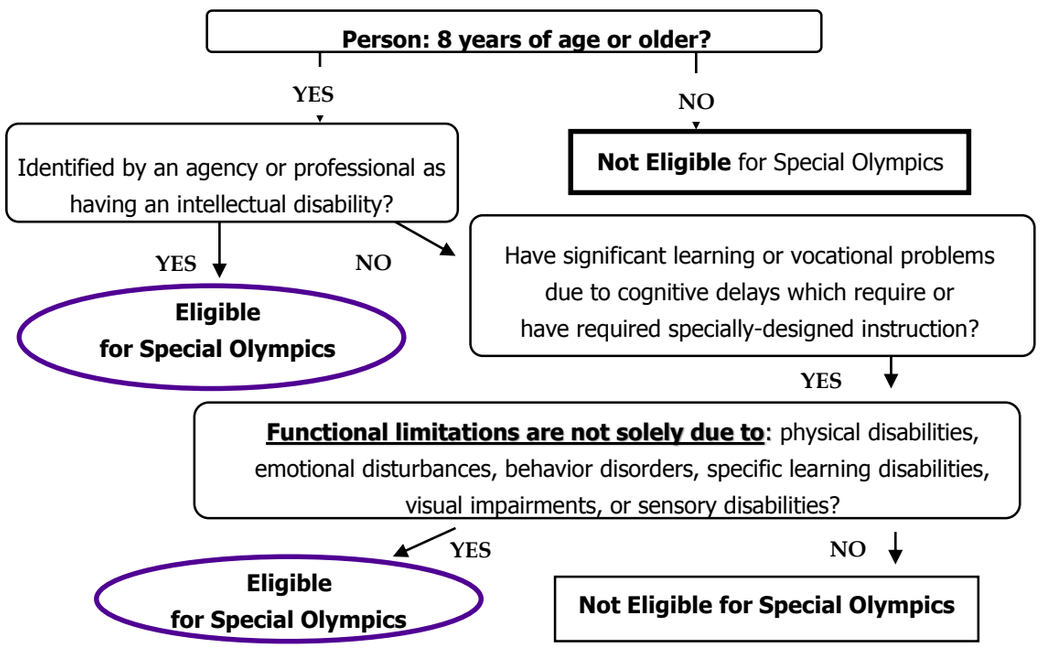
To be eligible for participation in Special Olympics, a competitor must agree to observe and abide by the Official Special Olympics Sports Rules.

Age Requirements

There is no maximum age limitation for participation in Special Olympics. The minimum age requirement for participation in Indy Stars Special Olympics Gymnastics Program is 8 years of age. For children with intellectual disabilities ages 2 through 7, we offer the adaptive gymnastics class which strengthens physical development and self-esteem by building skills for future sports participation and socialization.

Degree of Disability

Participation in Special Olympics training and competition is open to all persons with intellectual disabilities who meet the age requirements, regardless of the level or degree of that person's disability, and whether or not that person also has other mental or physical disabilities, so long as that person registers to participate in Special Olympics as required by the general rules.



Who should the Athlete Medical-Release Form go to?

1. **Original should be** given to the staff at Indy Stars Gymnastics
2. **Make copies for adult athlete/parent/guardian and a copy for coaches.**

Indy Stars Gymnastics

ATHLETE INFORMATION

First Name: | Middle Name: | Last Name:

Date Birth *(mm/dd//yyyy)*: | Female: ☐ Male: ☐ | Insurance:

Address: | Athlete's Primary Care Physician Name:

City State Zip | Athlete's Primary Care Physician Phone: ( ) -

Phone: ( ) - | Cell: ( ) - | Athlete's Primary Care Physician Address:

E-mail: | Eye color: | City/State/Zip:

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 and dates:

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, explain** _____
Has any relative died of a heart problem before age 40? ☐ No ☐ Yes
Has any family member or relative died while exercising? ☐ No ☐ Yes

Has the athlete ever had an abnormal Electrocardiogram (EKG)? or Echocardiogram (Echo)?
☐ No ☐ Yes *If yes, please circle EKG or Echocardiogram and describe below:*

Does the athlete currently have any chronic or acute infection?
☐ No ☐ Yes *If yes, please describe below:*

Has a doctor ever limited the athlete's participation in sports? ☐ No ☐ Yes If yes, please describe: _____

_____

Has the athlete had a Tetanus vaccine within the past 7 years? ☐ No ☐ Yes ***Is athlete his or her own guardian?*** ☐ **No** ☐ **Yes**

☐ PARENT OR ☐ GUARDIAN INFORMATION & ☐ EMERGENCY CONTACT INFORMATION (SAME AS PARENT/GUARDIAN)

First: | Middle: | Last:

Cell: ( ) - | ☐ Home Phone: ☐ Work ( ) -

E-mail: | Emergency Contact: Name & Number or ☐ Same as above

OVER

Athlete's Name: _____

Indy Stars Gymnastics

THIS PAGE TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE

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	Arthritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Easy 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 (diagnosed)	☐ No	☐ Yes
Anxiety (diagnosed)	☐ No	☐ Yes

Please describe any additional mental health concerns:

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW *(includes 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

Athlete Signature _____ Date _____ Legal Guardian Signature _____ Date _____

Athlete's Name:

INDY STARS GYMNASTICS OFFICIAL MEDICAL RELEASE

TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE

I am the parent/guardian or at least 18 years old and my own guardian and have submitted the attached application for participation in Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program. Permission has been given for the listed person to participate in Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program activities.

I further represent and warrant that to the best of my knowledge and belief, the Athlete is physically and mentally able to participate in Indy Stars Gymnastics Adaptive Gymnastics Program. A licensed medical professional has reviewed the health information set forth in the Athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the Athlete's participation. I understand that if the licensed medical professional has detected symptoms that might result from spinal cord compression, including Atlanto-axial Instability, then the Athlete will only be permitted to participate in Special Olympics sports training and competition if the Athlete has a thorough neurological evaluation from a physician who certifies that the Athlete may participate and I have signed a consent acknowledging that I have been informed of the findings of the physician.

In permitting the Athlete to participate, I am specifically granting my permission, forever, to Special Olympics to use the Athlete's likeness, name, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If a medical emergency should arise during the Athlete's participation in any Indy Stars Gymnastics Adaptive Gymnastics Program and Special Olympics Program activities, at a time when I am not personally present so as to be consulted regarding the athletes' care I hereby authorize Indy Stars Gymnastics, on my behalf, to provide emergency medical treatment including hospitalization, that Indy Star Gymnastics deems advisable in order to protect the athlete's health and well-being. **IF YOU HAVE RELIGIOUS OBJECTIONS TO RECIEVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH AND INITIAL HERE.**

I am the parent (guardian) of the Athlete named in this application or at least 18 years old and my own guardian. I have read and fully understand the provisions of the above release, and have explained these provisions to the Athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the Athlete named above.

I hereby give my permission for the Athlete named above or myself to participate in Special Olympics games, recreation programs, and physical activity programs.

_____ _____

Signature of Parent/Guardian/Adult Athlete (if own legal guardian) Date

OVER

Athlete's Name: _____

THIS PAGE TO BE COMPLETED BY MEDICAL EXAMINER ONLY

MEDICAL PHYSICAL INFORMATION

Height	Weight	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
in	lbs	F			BP Right	BP Left	**Right Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better **Left Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	Bowel Sounds	☐ Yes	☐ No	
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate	Hepatomegaly	☐ No	☐ Yes	
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	Splenomegaly	☐ No	☐ Yes	
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body	Abdominal Tenderness	☐ No	☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ	
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection ☐NA	Kidney Tenderness	☐ No	☐ Right ☐ Left	
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection ☐NA	Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Oral Hygiene	☐ Good	☐ Fair	☐ Poor	Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Thyroid Enlargement	☐ No	☐ Yes		Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Lymph Node Enlargement	☐ No	☐ Yes		Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	Abnormal Gait	☐ No	☐ Yes, describe _____	
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater	Spasticity	☐ No	☐ Yes, describe _____	
Heart Rhythm	☐ Regular	☐ Irregular		Tremor	☐ No	☐ Yes, describe _____	
Lungs	☐ Clear	☐ Not clear		Neck & Back Mobility	☐ Full	☐ Not full, describe _____	
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	Upper Extremity Mobility	☐ Full	☐ Not full, describe _____	
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+	Lower Extremity Mobility	☐ Full	☐ Not full, describe _____	
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R	Upper Extremity Strength	☐ Full	☐ Not full, describe _____	
Cyanosis	☐ No	☐ Yes, describe _____		Lower Extremity Strength	☐ Full	☐ Not full, describe _____	
Clubbing	☐ No	☐ Yes, describe _____		Loss of Sensitivity	☐ No	☐ Yes, describe _____	

☐ **Athlete does not have any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.**

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and therefore must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

RECOMMENDATIONS *(TO BE COMPLETED BY EXAMINER ONLY)*

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete is deemed to need further medical evaluation please utilize the Special Olympics Further Medical Evaluation Form, page 5 in order to provide the athlete with medical clearance.

☐ This athlete is **ABLE** to participate in Special Olympics sports. (Use Additional Licensed Examiner Notes for any restrictions or limitations).

☐ This athlete **MAY NOT** participate in Special Olympics sports at this time and must be evaluated by a physician for the following concerns:

☐ Concerning Cardiac Exam	☐ Acute Infection	☐ O_2 Saturation Less than 90% on Room Air
☐ Concerning Neurological Exam	☐ Stage II Hypertension or Greater	☐ Hepatomegaly or Splenomegaly

Other, please describe: _____

☐ **Additional Licensed Examiner's Notes:**

☐ Follow up with a cardiologist ☐ Follow up with a neurologist ☐ Follow up with a primary care physician

☐ Follow up with a vision specialist ☐ Follow up with a hearing specialist ☐ Follow up with a dentist or dental hygienist

☐ Follow up with a podiatrist ☐ Follow up with a physical therapist ☐ Follow up with a nutritionist

☐ Other: _____

Name: _____

E-mail: _____

Licensed Medical Examiner's Signature Date of Exam Phone: _____ License: _____

FURTHER MEDICAL EVALUATION FORM

(Only to be used if the athlete has previously not been cleared for sports participation above)

Examiner's Name:		**Examiner's Name:**	
Specialty:		**Specialty:**	

I have examined this athlete for the following medical concern(s):
Please describe

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete:

☐ Yes ☐ No May participate in Special Olympics sports (see below for restrictions or limitations)

☐ Additional Examiner Notes:

In my professional opinion, this athlete:

☐ Yes ☐ No May participate in Special Olympics sports (see below for restrictions or limitations)

☐ Additional Examiner Notes:

E-mail:		E-mail:	
Phone:		Phone:	
License:		License:	

Examiner's Signature Date

Examiner's Signature Date

This form has been adapted from the Special Olympics KY Medical Release Form