ATHLETE MEDICAL FORM — SPECIAL OLYMPICS CONNECTICUT

LOCAL PROGRAM: **PLEASE CHECK _____NEW _____RENEWAL**

Name (First – Last):		
Date of birth: _____/_____/_____	Gender ____Male ____Female	Phone Home:
Street:		
City:	State:	ZIP Code:

PLEASE LIST PARENT OR GUARDIAN INFORMATION BELOW

Name		
Address (if different than athlete's)		
City	State:	ZIP Code:
Phone Home:	Work:	Mobile:
E-Mail		

EMERGENCY CONTACT IF DIFFERENT THAN PARENT OR GUARDIAN

Name:	Relationship:	Phone:	Type:

HEALTH HISTORY TO BE COMPLETED BY PARENT/CAREGIVER

AN UP TO DATE HEALTH HISTORY AND A PHYSICAL EXAMINATION PERFORMED BY A LICENSED EXAMINER IS REQUIRED UPON ENTRY INTO THE PROGRAM. A PHYSICAL EXAMINATION IS REQUIRED EVERY 3 YEARS FOR ATHLETES WITH "YES" RESPONSES TO ITEMS 1 -5. A PHYSICAL EXAMINATION IS REQUIRED FOR ALL ATHLETES WITH A "NEW" RESPONSE TO ITEMS 7-11. ATHLETES MUST SUBMIT THIS FORM EVERY 3 YEARS WHETHER OR NOT AN EXAMINATION IS NECESSARY.

1. HEART PROBLEMS ___YES ___NO	9. SURGERY OR ILLNESS ___YES ___NO ___NEW	17. EMOTIONAL/BEHAVIOR PROBLEMS ___YES ___NO
2. CHEST PAINS ___YES ___NO	10.HEAT STROKE/COLD ILLNESS ___YES ___NO ___NEW	18. BONE OR JOINT DISORDER ___YES ___NO
3. SEIZURES/EPILEPSY ___YES ___NO	11. OTHER PROBLEM (S) THAT WOULD INTERFERE	19. SICKLE CELL/TRAIT DISEASE ___YES ___NO
4. DIABETES ___YES ___NO	WITH SPORTS PARTICIPATION ___YES ___NO ___NEW	20. HEARING AID ___YES ___NO
5. DOWN SYNDROME ___YES ___NO	LIST: _____	21. CONTACTS/EYEGLASSES ___YES ___NO
5a. Atlanto-Axial Instability present ___YES ___NO	12. IMPAIRED MOBILITY ___YES ___NO	22. DENTURES/FALSE TEETH ___YES ___NO
5b. If yes, X-ray date _____	13 DEAF ___YES ___NO	23. DATE OF LAST TETANUS SHOT _____/_____/____
6. BLIND ___YES ___NO ___NEW	14. SPECIAL DIET ___YES ___NO	24. INSECT STING ALLERGY ___YES ___NO
7.ABSENCE OF KIDNEY/TESTICLE ___YES ___NO ___NEW	15. ASTHMA ___YES ___NO	25. MEDICINE ALLERGY (LIST BELOW) ___YES ___NO
8. HEAD INJURY/CONCUSSION ___YES ___NO ___NEW	16. BLEEDING PROBLEMS ___YES ___NO	26.FOOD ALLERGY (LIST BELOW) ___YES ___NO

Check all that apply ____Non Verbal ____Walker ____Crutches ____Wheelchair ____Hepatitis

LIST MEDICINE ALLERGIES: **LIST FOOD ALLERGIES:**

MEDICATIONS: PLEASE PRINT MEDICATION NAME, AMOUNT AND NUMBER OF TIMES PER DAY MEDICATION NEEDS TO BE TAKEN BELOW: (USE ADDITIONAL PAPER IF NEEDED)

HEIGHT:_____ WEIGHT:_____

LICENSED EXAMINER AND PARENT/CAREGIVER SIGN AND DATE BELOW

EXAMINERS NOTE: If an 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 such 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).

RESTRICTIONS:	DATE: _____/_____/_____
EXAMINERS SIGNATURE:	DATE: _____/_____/_____
EXAMINERS NAME:	PHONE: ( )
APPLICANT OR PARENT/GUARDIAN SIGNATURE:	DATE: _____/_____/_____

THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED AND DATED TO BE CONSIDERED VALID.