Agency Number ___________________

SPECIAL OLYMPICS	HEALTH HISTORY	MEDFEST

Athlete Name: Date of Birth: ☐ Male ☐ Female

☐ African	☐ American Indian/Eskimo	☐ Middle Eastern	☐ Asian/Pacific Islander	☐ Australian Aboriginal
☐ Caucasian	☐ Hispanic/Latin American	☐ Mix (check all that apply)	☐ Other:	

Social Security # (if US citizen) : Day Phone #: Night Phone #:

Health Insurance Company: Policy #:

Athlete's Address: City: State:

Parent/Guardian Name: Day Phone #: Night Phone #:

Parent/Guardian Address: City: State:

Primary Care Physician's Name: Day Phone #:

Primary Care Physician's Address: City: State:

Emergency Contact Name: Day Phone #: Night Phone #:

Do you have any religious objections to medical treatment? ☐No ☐Yes, Please Describe:

Where do you live? ☐ With Parents or Other Family Members ☐ Independently ☐ Group Home ☐ Institution/Facility

Please list any medications, vitamins or dietary supplements below (include birth control or hormone therapy, if applicable).

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

Please check which of the following vaccines the athlete has had.

☐ Anthrax	☐ Influenza (flu)	☐ Pertussis (DTP)	☐ Small Pox
☐ Chickenpox (VZV)	☐ Japanese Encephalitis	☐ Pneumococcus	☐ Tetanus (DTP) Year of last dose:________
☐ Diphtheria (DTP)	☐ Lyme Disease	☐ Polio	
☐ Hepatitis A	☐ Measles (MMR)	☐ Rabies	☐ Tuberculosis
☐ Hepatitis B	☐ Meningococcus	☐ Rotavirus	☐ Typhoid Fever
☐ Hemophilus Influenza B	☐ Mumps (MMR)	☐ Rubella (MMR)	☐ Yellow Fever

List any allergies	List any special diet needs

List all past or ongoing medical conditions	List all past surgeries

List any medical conditions which run in your family	Which sports are you interested in playing?

Please answer the following questions (circle questions you do not know the answer to).

How long has it been since you visited an emergency room?	How long has it been since you visited a physician?
How many times did you visit an emergency room last year?	How many times did you visit a physician last year?
Have you ever had a seizure in your lifetime? ☐Yes ☐No	Do you take birth control or another hormone therapy? ☐Yes ☐No
Have you had a seizure in the last 12 months? ☐Yes ☐No	Have you taken antibiotics in the past month? ☐Yes ☐No
Has any family member or relative died while exercising? ☐Yes ☐No	Do you have burning or discomfort when urinating? ☐Yes ☐No
Has any relative died of a heart problem before age 40? ☐Yes ☐No	Do you currently have any symptoms of a cold or flu? ☐Yes ☐No

Do you currently have any chronic or acute infection? ☐No ☐Yes, please describe?:

Have you ever had an abnormal Electrocardiogram (EKG)? ☐No ☐Yes, why?:

Have you ever had an abnormal Echocardiogram (Echo)? ☐No ☐Yes, why?:

Has a doctor ever limited your participation in sports ? ☐No ☐Yes, why?:

Athlete Name ________________ Agency Number ________________

What is the medical cause of the athlete's intellectual disability?	List any additional conditions or syndromes (see list below)

Adams-Oliver Syndrome	Ehler-Danlos Syndrome	Kearns-Sayre Syndrome	Townes-Brocks Syndrome
Allagile Syndrome	Eisenmenger Syndrome	Laurence-Moon-Biedle Syndrome	Treacher Collins Syndrome
Apert Syndrome	Ellis Van Crevald Syndrome	Leopard Syndrome	Tuberous Sclerosis
Cantrell Syndrome	Emery-Dreifuss Dystrophy	Marfan Syndrome	Turner Syndrome
Carpenter Syndrome	Fanconi Anemia	Mucopolysaccharidosis	VACTERL Syndrome
Cayler Syndrome	Farber Syndrome	Muscular Dystrophy	VATER Syndrome
CHARGE Syndrome	Fetal Alcohol Syndrome	Osler-Weber-Rendu Syndrome	Velo-Cardio-Facial Syndrome
Congenital Rubella Syndrome	Fragile X Syndrome	Progeria	Von Hippel Lindau Syndrome
De Lange Syndrome	Friedreich Ataxia	Scimitar Syndrome	William-Beuren Syndrome
Dejerin-Soltas Syndrome	Hemorrhagic Telangiectasia	Shones Syndrome	Williams Syndrome
DiGeorge Syndrome	Heterotaxy Syndrome	Shprintzen Syndrome	Wolff-Parkinson-White Syndrome
Down Syndrome	Holt-Oram Syndrome	Smith Magenis Syndrome	Zellweger Syndrome
Dubowitz Syndrome	Ivemark Syndrome	Smith-Lemli-Opitiz Syndrome	
Edwards Syndrome	Kartagener Syndrome	TAR Syndrome	

Please indicate if you have ever had any of the following conditions (circle questions you do not know the answer to).

SECTION 1 (CR)

Condition		
Chest Pain During or After Exercise	☐Yes	☐No
Dizziness During or After Exercise	☐Yes	☐No
Fainting During or After Exercise	☐Yes	☐No
Headache During or After Exercise	☐Yes	☐No
Irregular Heart Beat	☐Yes	☐No
Loss of Consciousness	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Skipped Heart Beats	☐Yes	☐No
Arrhythmogenic Right Ventricular Hypertrophy	☐Yes	☐No
Dilated Cardiomyopathy	☐Yes	☐No
Endocarditis	☐Yes	☐No
Heart Defect	☐Yes	☐No
Heart Disease	☐Yes	☐No
Heart Infection	☐Yes	☐No
Heart Murmur	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
High Cholesterol	☐Yes	☐No
Hypertrophic Cardiomyopathy	☐Yes	☐No
Left Ventricular Hypertrophy	☐Yes	☐No
Long QT Syndrome	☐Yes	☐No
Pericarditis	☐Yes	☐No
Racing Heart Beat	☐Yes	☐No

SECTION 2 (TR)

Condition		
Atlanto-Axial Instability	☐Yes	☐No
Broken Bones (More Than One)	☐Yes	☐No
Concussions (More Than One)	☐Yes	☐No
Dislocated Joints (More Than One)	☐Yes	☐No
Easy Bleeding	☐Yes	☐No
Enlarged Spleen	☐Yes	☐No
Hepatitis	☐Yes	☐No
Osteogenesis Imperfecta	☐Yes	☐No
Osteopenia or Osteoporosis	☐Yes	☐No
Spina Bifida	☐Yes	☐No
Burner, stinger or pinched nerve in neck, arms, shoulders/hands	☐Yes	☐No
Difficulty controlling bowels	☐Yes	☐No
Difficulty controlling bladder	☐Yes	☐No
Numbness in arms or hands	☐Yes	☐No
Numbness in legs or feet	☐Yes	☐No
Tingling in arms or hands	☐Yes	☐No
Tingling in legs or feet	☐Yes	☐No
Weakness in arms or hands	☐Yes	☐No
Weakness in legs or feet	☐Yes	☐No
Recent change in coordination	☐Yes	☐No
Recent change in ability to walk	☐Yes	☐No

SECTION 3 (ER)

Condition		
Asthma	☐Yes	☐No
Diabetes (Type I)	☐Yes	☐No
Diabetes (Type II)	☐Yes	☐No
Ectodermal Dysplasia	☐Yes	☐No
Heat Exhaustion	☐Yes	☐No
Heat Stroke	☐Yes	☐No
Sickle Cell Disease	☐Yes	☐No
Sickle Cell Trait	☐Yes	☐No
Single Kidney	☐Yes	☐No
Thyroid Disease	☐Yes	☐No

SECTION 4 (PR)

Condition		
Aggressive Behavior (AB)	☐Yes	☐No
AB during the past year?	☐Yes	☐No
Self-Injurious Behavior (SIB)	☐Yes	☐No
SIB during the past year?	☐Yes	☐No
Autism	☐Yes	☐No
Attention Deficit/Hyperactivity	☐Yes	☐No
Bipolar Mood Disorder	☐Yes	☐No
Depression	☐Yes	☐No
Psychosis	☐Yes	☐No
Schizophrenia	☐Yes	☐No

Athletes with Down syndrome, please answer the following questions.

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 such a radiological examination is required are: judo, equestrian sports, gymnastics, diving, pentathlon, diving starts in swimming, butterfly stroke, high jump, alpine skiing, snowboarding, squat lift, and football (soccer) competition.

Has an x-ray evaluation for Atlanto-Axial Instability been done? ☐Yes ☐No | If yes, was it positive for Atlanto-Axial Instability? ☐Yes ☐No

Please sign and date.

Athlete Signature Date	Legal Guardian Signature Date
Print Name	Print Name