

Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)



Athlete's First and Last Name: _____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI (optional)	Temperature	Pulse	O ₂ Sat	Blood Pressure (in mmHg)		Vision		
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
in	lbs	Body Fat %	F					Left Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		

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

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)

- Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.
- OR**
- Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

ATHLETE CLEARANCE TO PARTICIPATE (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 needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

- This athlete is **ABLE** to participate in Special Olympics sports without restrictions.
- This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe → _____
- This athlete **MAY NOT participate** in Special Olympics sports at this time & **MUST** be further evaluated by a physician for the following concerns:
- | | | |
|--|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam | <input type="checkbox"/> Acute Infection | <input type="checkbox"/> O ₂ Saturation Less than 90% on Room Air |
| <input type="checkbox"/> Concerning Neurological Exam | <input type="checkbox"/> Stage II Hypertension or Greater | <input type="checkbox"/> Hepatomegaly or Splenomegaly |
| <input type="checkbox"/> Other, please describe: _____ | | |

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- | | | |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist | <input type="checkbox"/> Follow up with a neurologist | <input type="checkbox"/> Follow up with a primary care physician |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist |
| <input type="checkbox"/> Other/Exam Notes: _____ | | |

Signature of Licensed Medical Examiner	Exam Date	Name: _____
		E-mail: _____
		Phone: _____ License #: _____