

ATHLETE APPLICATION FOR PARTICIPATION



Athlete Name: _____ ID#: _____ Office Only

Patient Last Name: _____ First: _____ DOB: _____

PHYSICAL EXAMINATION: Must be filled out by a: MD PA NP DO Other: _____
(This form cannot be filled out by a chiropractor).

I have attached one of the following acceptable substitutes for this form: Yes No
 (School) Sports Physical Annual Physical Exam with Physician Statement of Consent for Participation
(Physician must clearly state that the athlete is "cleared/able" to participate in Special Olympics/sports/recreational activities).

Height: _____ Weight: _____ BMI: _____ Body Fat%: _____ Pulse: _____ O₂Sat: _____ BP: _____

Vision = 20/40 or better	<input type="checkbox"/> Yes (L/R)	<input type="checkbox"/> No (L/R)	<input type="checkbox"/> NA	Bowel Sounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing (Response)	<input type="checkbox"/> Yes (L/R)	<input type="checkbox"/> No (L/R)	<input type="checkbox"/> NA	Hepatomegaly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ear Canal	<input type="checkbox"/> Clear (L/R)	<input type="checkbox"/> Cerumen (L/R)	<input type="checkbox"/> Foreign Body (L/R)	Splenomegaly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Tympanic Membrane	<input type="checkbox"/> Clear (L/R)	<input type="checkbox"/> Perforation (L/R)	<input type="checkbox"/> Infection (L/R)	Abdominal Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> RUQ	<input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ
Oral Hygiene	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Kidney Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> Right	<input type="checkbox"/> Left
Heart Murmur (Supine(S) & Upright (U))	<input type="checkbox"/> No (S/U)	<input type="checkbox"/> 1/6 -2/6 (S/U)	<input type="checkbox"/> 3/6↑ (S/U)	Extremity Reflexes (Upper (U) & Lower (L))	<input type="checkbox"/> Normal (U/L & R/L)	<input type="checkbox"/> Diminished (U/L & R/L)	<input type="checkbox"/> Hyperreflexia (U/L & R/L)
Lymph Nodes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____	Thyroid	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	_____
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular	_____	Spasticity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not Clear	_____	Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Leg Edema	<input type="checkbox"/> No (L/R)	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ (L/R)	Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not Full	_____
Radial Pulse Symmetry	<input type="checkbox"/> Yes	<input type="checkbox"/> R>L	<input type="checkbox"/> L>R	Extremity Mobility	<input type="checkbox"/> Full (U/L)	<input type="checkbox"/> Not Full (U/L)	_____
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Extremity Strength	<input type="checkbox"/> Full (U/L)	<input type="checkbox"/> Not Full (U/L)	_____
Abnormal Gait	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Other:	_____		

ATLANTOAXIAL INSTABILITY (AAI)

- Athlete shows **NO EVIDENCE** of neurological systems or physical findings associated with spinal cord compression or Atlantoaxial Instability.
- Athlete has neurological systems or physical findings that could be associated with spinal cord compression or Atlantoaxial Instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation. *(Please call or email for the Atlantoaxial Instability Special Release Form to take to your neurological evaluation).*

MEDICAL PROFESSIONAL'S RECOMMENDATION

- This athlete **IS ABLE** to participate in Special Olympics sports without restrictions/limitations.
- This athlete is able to participate in Special Olympics sports WITH RESTRICTIONS/LIMITATIONS.

RESTRICTIONS/LIMITATIONS:

This athlete **MAY NOT PARTICIPATE** in Special Olympics sports, at this time, and must be further evaluated by a physician. Please call or email for the *Special Olympics Further Medical Examination Form* to take to your next examination for the following concerns: Cardiac Acute Infection O₂ Saturation < 90% on Room Air
 Neurology Stage II Hypertension or Greater Hepatomegaly/Splenomegaly Other: _____

Referrals: Cardiologist Neurologist Primary Care Physician Vision Specialist Hearing Specialist Dentist/Dental Hygienist
 Podiatrist Physical Therapist Nutritionist Other/Notes: _____

Name: _____ License: _____

Email: _____ Phone: _____

Address/Stamp: _____

Licensed Medical Professional's Signature _____ Date of Exam _____