ATHLETE – FURTHER EXAMINATION FORM

Patient Last Name: ____________________ **First**: ______________ **DOB:** _________ ID#: Office Only _____

ATHLETE: Please have a physician complete this form, if you/the athlete required further medical examinations in order to be "cleared" to participate in Special Olympics. Please attach and submit this form with the Special Olympics Colorado ATHLETE APPLICATION FOR PARTICIPATION. If more than one additional examination is required, please make as many copies of this form as needed for each additional examination.

LICENSED MEDICAL PROFESSIONAL: You have been asked to fill out this form because the previous doctor recommended that this athlete MAY NOT PARTICIPATE until further evaluated. Thus, this form must address the previous doctor's concerns. If it does not address the previous doctor's concerns, the athlete will still need to be evaluated for all the health concerns that the previous doctor noted. In addition, this form should be filled out by a licensed physician specializing in the areas of concern.

Physician's Name ________________________________ **Specialty:** ____________________

I have been asked to exam this athlete for the following medical concern(s):
☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O^2 Saturation Less Than 90% on Room Air
☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly
☐ Splenomegaly ☐ Other:

PHYSICIAN'S RECOMMENDATION

In my professional opinion…

☐ 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: ____

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☐ This athlete **REQUIRES FURTHER EXAMINATION** for the following concerns:
☐Cardiac ☐Acute Infection ☐O2 Saturation < 90% on Room Air ☐Neurology
☐Stage II Hypertension or Greater ☐Hepatomegaly/Splenomegaly
☐Other: ____

☐ This athlete **MAY NOT PARTICIPATE** in Special Olympics sports.

Physician's License: ______________________

Email: ____________________ Phone: __________
Address/Stamp:

Physician's Signature ______________ Date of Exam ______________