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: _____ O_2Sat: _____ BP: _____

Vision = 20/40 or better ☐Yes (L/R) ☐No (L/R) ☐NA

Hearing (Response) ☐Yes (L/R) ☐No (L/R) ☐NA

Ear Canal ☐Clear (L/R) ☐Cerumen (L/R) ☐Foreign Body (L/R)

Tympanic Membrane ☐Clear (L/R) ☐Perforation (L/R) ☐Infection (L/R)

Oral Hygiene ☐Good ☐Fair ☐Poor _____

Heart Murmur (Supine(S) & Upright (U)) ☐No (S/U) ☐1/6 -2/6 (S/U) ☐3/6↑ (S/U)

Lymph Nodes ☐Normal ☐Abnormal _____

Heart Rhythm ☐Regular ☐Irregular _____

Lungs ☐Clear ☐Not Clear _____

Cyanosis ☐No ☐Yes _____

Leg Edema ☐No (L/R) ☐1+ ☐2+ ☐3+ ☐4+ (L/R)

Radial Pulse Symmetry ☐Yes ☐R>L ☐L>R

Clubbing ☐No ☐Yes _____

Abnormal Gait ☐No ☐Yes _____

Bowel Sounds ☐Yes ☐No _____

Hepatomegaly ☐Yes ☐No _____

Splenomegaly ☐Yes ☐No _____

Abdominal Tenderness ☐No ☐RUQ ☐RLQ ☐LUQ ☐LLQ

Kidney Tenderness ☐No ☐Right ☐Left

Extremity Reflexes (Upper (U) & Lower (L)) ☐Normal (U/L & R/L) ☐Diminished (U/L & R/L) ☐Hyperreflexia (U/L & R/L)

Thyroid ☐Normal ☐Abnormal

Spasticity ☐No ☐Yes _____

Tremor ☐No ☐Yes _____

Loss of Sensitivity ☐No ☐Yes _____

Neck & Back Mobility ☐Full ☐Not Full _____

Extremity Mobility ☐Full (U/L) ☐Not Full (U/L)

Extremity Strength ☐Full (U/L) ☐Not Full (U/L)

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: _____

Licensed Medical Professional's Signature _____ Date of Exam _____

Email: _____ Phone: _____

Address/Stamp: