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_2Sat	Blood Pressure (in mmHg)		Vision			
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better	No	Yes	N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better	No	Yes	N/A

Right Hearing (Finger Rub)	Responds	No Response	Can't Evaluate	
Left Hearing (Finger Rub)	Responds	No Response	Can't Evaluate	
Right Ear Canal	Clear	Cerumen	Foreign Body	
Left Ear Canal	Clear	Cerumen	Foreign Body	
Right Tympanic Membrane	Clear	Perforation	Infection	NA
Left Tympanic Membrane	Clear	Perforation	Infection	NA
Oral Hygiene	Good	Fair	Poor	
Thyroid Enlargement	No	Yes		
Lymph Node Enlargement	No	Yes		
Heart Murmur (supine)	No	1/6 or 2/6	3/6 or greater	
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater	
Heart Rhythm	Regular	Irregular		
Lungs	Clear	Not clear		
Right Leg Edema	No	1+ 2+	3+ 4+	
Left Leg Edema	No	1+ 2+	3+ 4+	
Radial Pulse Symmetry	Yes	R>L	L>R	
Cyanosis	No	Yes, describe		
Clubbing	No	Yes, describe		

Bowel Sounds	Yes	No			
Hepatomegaly	No	Yes			
Splenomegaly	No	Yes			
Abdominal Tenderness	No	RUQ	RLQ	LUQ	LLQ
Kidney Tenderness	No	Right	Left		
Right upper extremity reflex	Normal	Diminished	Hyperreflexia		
Left upper extremity reflex	Normal	Diminished	Hyperreflexia		
Right lower extremity reflex	Normal	Diminished	Hyperreflexia		
Left lower extremity reflex	Normal	Diminished	Hyperreflexia		
Abnormal Gait	No	Yes, describe below			
Spasticity	No	Yes, describe below			
Tremor	No	Yes, describe below			
Neck & Back Mobility	Full	Not full, describe below			
Upper Extremity Mobility	Full	Not full, describe below			
Lower Extremity Mobility	Full	Not full, describe below			
Upper Extremity Strength	Full	Not full, describe below			
Lower Extremity Strength	Full	Not full, describe below			
Loss of Sensitivity	No	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:**

- Concerning Cardiac Exam
- Concerning Neurological Exam
- Other, please describe:
- Acute Infection
- Stage II Hypertension or Greater
- O_2 Saturation Less than 90% on Room Air
- Hepatomegaly or Splenomegaly

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

- Follow up with a cardiologist
- Follow up with a vision specialist
- Follow up with a podiatrist
- Follow up with a neurologist
- Follow up with a hearing specialist
- Follow up with a physical therapist
- Follow up with a primary care physician
- Follow up with a dentist or dental hygienist
- Follow up with a nutritionist

Other/Exam Notes:

Name:

E-mail:

Signature of Licensed Medical Examiner Exam Date Phone: License #: