SPECIAL OLYMPICS COLORADO PHYSICAL EXAMINATION FORM

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 contact the Help Desk 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 contact the Help Desk 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:

Please upload form: ■ **Help Desk:** https://specialolympicsco.org/getinvolved/becomeanathlete/helpdesk/
■ **Online:** https://specialolympicsco.org/getinvolved/becomeanathlete/athlete-application/