LUCAS COUNTYSPECIAL OLYMPICS
1154 LARC LANE • TOLEDO, OH 43614
(419) 380-5115 • FAX (419) 380-2636

Lucas County Board of Developmental Disabilities
creating connections, **inspiring** possibilities

Dear Interested Athlete:

Thank you for your interest in Lucas County Special Olympics. In order to participate in our program, you must be at least 16 years old, have a qualifying diagnosis and have a current Special Olympics medical form on file with our office.

We have included the medical forms that need filled out. You will need to complete and sign the health history and release form. **Please make sure that the physical examination section is completely filled out by your physician and signed.** Make sure to have them include any restrictions you may have. These forms are valid up to three (3) years from the date of the physician's signature on the form.

*(Note: Athletes who have **Down Syndrome** who wish to participate in the sports listed on the medical form in the section pertaining to Atlanto-axial instability must also have a written release from a physician stating that they have been examined and that X-rays have been taken showing no evidence of Atlanto-axial instability. This examination is required only once and a copy of the report will be kept on file.)*

Please return completed forms to **Lucas County Special Olympics, Attn: Lisa Martin** via:
Email: specialolympics@lucasdd.org **Preferred and fastest method
Mail: 1154 Larc Lane, Toledo, OH 43614
Or Fax: 419-380-2636

The enclosed Lucas County Special Olympics **Fact Sheet** will give you more details about our program and the sports offered.

Upon receipt of your medical form, your information will be added to our database and you will begin to receive emails each quarter with information of the upcoming sports seasons and how to sign up.

Thanks again for your interest.

Sincerely,

Kelly Watson
Lucas County Special Olympics
Recreation Specialist

Special Olympics Ohio Lucas County

Lucas County Special Olympics (LCSO)

Fact Sheet

Eligibility: In order to participate in LCSO, an individual must reside in Lucas County and be at least 16 years of age. All participants must have a doctor signed Special Olympics medical form on file and documentation that the participant meets one of the following requirements:

1. The person has been identified by an agency or professional as having an intellectual disability; or
2. The person has a cognitive delay as determined by standardized measure; or
3. The person has a closely related developmental disability which means having functional limitations in general learning and adaptive skills.

Sports Currently Offered: Alpine skiing, aquatics (swimming), athletics (track and field), basketball, bocce, bowling, cycling, flag football, golf, power lifting, softball, tennis, and volleyball. In addition, we offer the following unified (individuals with and without disabilities participating together) sports: golf and bowling.

Information Sharing: You will receive 3-4 mailings each year about LCSO training programs, news about LCSO athletes and coaches, and updates on fundraising. Please follow instructions in the mailings to register for sport training programs. Mailings are sent to athletes who have a current medical form on file with our office. So that more athletes can participate, we ask that you train in only one sport per season.

Fund Raising: According to Special Olympic rules, training and competition is free to LCSO athletes (exceptions are alpine skiing, golf, and bowling). Each year we have expenses related to umpires/referees, facility fees, competition/entry fees, equipment, uniforms, charter bus rental, and meals / lodging when we attend State Competition. These costs must be covered by donations and fundraising. LCSO expects that all who participate will take part in our fundraising efforts. If funds are not available, the number of athletes attending or participation in an event may be affected. If you or your family member would like to be a part of our fund raising committee, please contact our office.

Code of Conduct: All athletes, volunteers, spectators, and coaches must abide by the Special Olympic Code of Conduct. This Code of Conduct is discussed at the beginning of each training season and athletes and/or their guardian sign a form indicating they have received and understand it. Violations of the code of conduct may result in suspension from competitions and/or the program. Smoking and the use of alcohol are not allowed at any Special Olympic program or event or while in uniform.

Personal Safety: Please be advised that some of the individuals who participate in LCSO have personal space issues. We ask that all athletes and volunteers treat each other respectfully and limit physical contact to handshakes and high fives**.**

Supervision: It is not the role of LCSO staff to provide supervision to anyone at any practice, competition or overnight stays. As a result, if an athlete requires supervision for any safety, medical, dietary and/or behavioral concerns, they must be accompanied by an adult family member or a homemaker/personal care staff that is familiar with their needs. Please note that LCSO staff, volunteers, and coaches have not been trained on athletes' Person Centered and Specialized Support Plans so we are unaware of potential concerns. LCSO athletes attending competitions involving an overnight stay generally share rooms with other athletes. Chaperones are housed in nearby rooms.

Have any questions? Please contact:

Kelley Watson, LCSO Recreation Specialist-Local SO Coordinator
(419) 380-5109 or kwatson@lucasdd.org

Lucas County Special Olympics
1154 Larc Lane
Toledo, OH 43614
(419) 419-380-5115

Athlete Medical Form-Health History

(pages 1 & 2 to be completed by the athlete or parent /guardian/caregiver)

Special Olympics Ohio

County

Organization

ATHLETE INFORMATION

First Name | Middle Name: | Last Name

Date of birth month/day/year | Female ☐ Male ☐

Address (Street)

Address (City, State, Zip):

Phone: | Cell:

E-mail:

Eye color: | Ethnicity: (voluntary)

Employer:

I am my own guardian. ☐ Yes ☐ No

Does the athlete have *(check any that apply)*:

☐ Autism ☐ Down syndrome ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome

☐ Other syndrome, please specify:

Is the athlete allergic to any of the following *(please list)*:

☐ Latex ☐ No Known Allergies

☐ Medications:

☐ Insect Bites or Stings:

☐ Food:

List any special dietary needs:

List all past surgeries:

Does the athlete currently have any chronic or acute infection?

☐ No ☐ Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or an abnormal Echocardiogram (Echo)? *If yes, select below and describe*

☐ Yes, had abnormal EKG ☐ Yes, had abnormal Echo

☐ PARENT ☐ GUARDIAN INFORMATION *(if not own guardian)*

Name:

Phone: | Cell:

E-mail:

Emergency Contact Name: | Same as Above: ☐

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the Athlete have a Primary care Physician: ☐ Yes ☐ No *If yes, list*

Physician Name: | Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?

☐ No ☐ Yes *If yes, contact your local Program to get the Emergency Care Refusal Form.*

List any sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

☐ No ☐ Yes *If yes, please describe:*

Does the athlete use *(check any that apply)*:

☐ Brace ☐ Colostomy ☐ Communication Device

☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures

☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid

☐ Implanted Device ☐ Inhaler ☐ Pacemaker

☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes

Has any family member or relative died while exercising? ☐ No ☐ Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form Health History

(pages 1 & 2 to be completed by the athlete or parent /guardian/caregiver)

Athlete's name

Special Olympics Ohio

Athlete's Name

INDICATE IF THE ATHLETE HAS EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Stroke/TIA	☐ No	☐ Yes
Dizziness during or after exercise	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	Concussions	☐ No	☐ Yes
Headache during or after exercise	☐ No	☐ Yes	Vision Impairment	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Chest pain during or after exercise	☐ No	☐ Yes	Hearing Impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Shortness of breath during or after exercise	☐ No	☐ Yes	Enlarged Spleen	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Irregular, racing or skipped heat beats	☐ No	☐ Yes	Single Kidney	☐ No	☐ Yes	Urinary Discomfort	☐ No	☐ Yes
Congenital Heart Defect	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes	Spina Bifida	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes	Osteopenia	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Easy Bleeding	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ Yes
Endocarditis	☐ No	☐ Yes						

Difficulty controlling bowels or bladder ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Numbness or tingling in legs, arms, hands or feet ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Weakness in legs, arms, hands or feet ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Head Tilt ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Spasticity ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Paralysis ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ **No** ☐ **Yes**

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above):*

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

If yes, list seizure type:

If yes, had seizure during the past year? ☐ No ☐ Yes

Self-injurious behavior during the past year ☐ No ☐ Yes

Aggressive behavior during the past year ☐ No ☐ Yes

Depression (diagnosed) ☐ No ☐ Yes

Anxiety (diagnosed) ☐ No ☐ Yes

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW *(includes inhalers, birth control or hormone therapy)*

Medication, Vitamin or Supplement	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

If female athlete, list date of last menstrual period:

Athlete signature(If own guardian) **Date**

Guardian Signature(Only needed if not won guardian) **Date**

Relationship to Athlete

Athlete Medical Form-Physical Examination

(to be completed by a **Medical Professional** *only*

Special Olympics Ohio

Athlete's Name

MEDICAL PHYSICAL INFORMATION *(TO BE COMPLETED BY EXAMINER ONLY)*

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
cm / in	kg / lbs	BMI / Body Fat %	C / F			BP Right:	BP Left:	Right Vision ☐ No ☐ Yes ☐ N/A 20/40 or better Left Vision ☐ No ☐ Yes ☐ N/A 20/40 or better

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		

☐ **Athlete shows no evidence of any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.**

☐ **Athlete has neurological symptoms 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.**

********RECOMMENDATIONS** *(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 is deemed to need further medical evaluation please utilize the Special Olympics Further Medical Evaluation Form, page 4, in order to provide the athlete with medical clearance.

☐ **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:** →

☐ **This athlete MAY NOT participate in Special Olympics sports at this time and MUST be further evaluated by a physician for the following concerns:**

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O_2 Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly

☐ Other, please describe:

Additional Licensed Examiner's Notes and Recommended Follow-up:

☐ Follow up with a cardiologist ☐ Follow up with a neurologist ☐ Follow up with a primary care physician

☐ Follow up with a vision specialist ☐ Follow up with a hearing specialist ☐ Follow up with a dentist or dental hygienist

☐ Follow up with a podiatrist ☐ Follow up with a physical therapist ☐ Follow up with a nutritionist

☐ Other/Exam Notes:

Name:

Email:

Licesnsed Medical Examiner's Signature Date of Exam Phone: License:

Athlete Medical Form- Medical Referral Form

(to be completed by a **Medical Professional only if referral is needed)**

Special Olympics Ohio

Athlete's Name

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates follow-up is required. Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete MAY participate in Special Olympics sports (indicate restrictions or limitations below):

☐ **Yes, without restrictions** ☐ **Yes, but with restrictions** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail:

Examiner Phone:

License:

Examiner's Signature **Date**

This Section to be completed by Special Olympics Staff Only, if applicable.

This medical exam was completed at a MedFest Event? ☐ Yes ☐ No

The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete

ATHLETE RELEASE FORM

Special Olympics

I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.

2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.

3. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.

4. **Emergency Care.** If I am unable, or my guardian is unavailable, to make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I check one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment.
   ☐ I do not consent to blood transfusions.
   (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Special Olympics athletes (identifying information removed if shared publically); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and change my information.

   I understand Special Olympics is a global organization with headquarters in the United States of America. I consent to Special Olympics processing my information in countries with different privacy and data security laws, including the United States of America.

ATHLETE NAME: _____

ATHLETE SIGNATURE (required for athlete over 18 years old with capacity to sign legal documents)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required for athlete under 18 years old or lacking capacity to sign legal documents)

I am a parent or guardian of the Athlete. I have read and understand this form and have explained the contents to the Athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Athlete.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____