Lucas County Board of Developmental Disabilities

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

Special Olympics Ohio

Dear Interested Athlete:

Thank you for your interest in Lucas County Special Olympics. In order to participate in our Special Olympics program, you must have a current Special Olympics medical form on file with our office.

Please take the enclosed Special Olympics Medical Form to your doctor and have it completed and signed. You can complete most of the form yourself. **Please make sure that the physical examination section is completely filled out by your physicians, including any restrictions**. Forms are valid up to three (3) years from the earliest date and 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.)*

You (or your legal guardian if you have one) must sign **both** sides of the Medical Form.

Also enclosed is a form used to build our **database** of Special Olympics athletes. Please return completed forms to:

Lucas County Special Olympics
1154 Larc Lane
Toledo, OH 43614
Or Fax: 419-380-2636

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

Upon receipt of your medical form, your information will be added to our database and you will begin to receive mailings each quarter.

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

Special Olympics Ohio

Special Olympics Ohio new Medical and Release Forms

Special Olympics Incorporated has issued new medical and release forms that State Chapters must begin using. Special Olympics Ohio 2012 (version) medical forms that are dated prior to April 1, 2017 will still be valid for 3 years as of the physician's signature. After this date, all programs must use the new forms that are attached.

Please print clearly on this form

Health History

Pages 1-2 need to be filled out prior to the athlete's medical examination. The name of person completing pages 1 and 2 needs to be filled out on the bottom of page 2. Please fill out as much information as possible.

Areas on page (1) one that must be filled out include: Athlete's name, age and gender. On page (2) two: athlete's name and person completing the form

Athlete Release Form

Page 3 is the Athlete Release form this page needs to be filled out and signed by a parent or guardian. If the athlete is signing the form and is over 18 they need to sign at the participant signature line. There are no changes that can be made to the wording on this form for an athlete to be allowed to participate. There must be a signature and date on this form.

Physical Examination

Make sure the athlete's name is filled out at the top of this form, all information the doctor feels comfortable completing will be accepted. **A doctor's signature and date must be on page 4 of this form, no attached medicals or signatures will be accepted. The doctor must fill out the recommendations area of participation.**

Medical Referral Form

This page is only to be used if a doctor determines that an athlete needs further examination to a specialist prior to any involvement in Special Olympics.

Special Olympics Ohio
3303 Winchester Pike, Columbus, 43232, Tel 614.239.7050 Fax 614.239.1873
www.sooh.org Twitter sooh.io

ANNOUNCING

Through a partnership with

ProMedica Sports Care Physicians

and

Special Olympics Ohio

Special Olympics physicals are now available

AT NO COST!!!

The ProMedica Sports Care Physicians will schedule up to 3 physicals per week at their office located at:

2685 N. Reynolds, Toledo, Suite 140

To schedule your appointment call: **419-578-7590.**

*** You will need to take a Special Olympics physical form with you, with as much completed as possible, to the appointment.*

****Please let Kelley, Liz, Lisa or Mary Beth know if you plan on using this service.** *Only 150 physicals per year can be scheduled.*

Special Olympics Ohio
Lucas County

PROMEDICA

Athlete Medical Form – HEALTH HISTORY

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

Special Olympics Ohio

County:

Organization:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date of Birth *(mm/dd/yyyy)*: Female: ☐ Male: ☐

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Eye color: Ethnicity: (voluntary)

Athlete Employer, if any:

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 athlete or parent/guardian/caregiver)

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**

Legal Guardian Signature *(only needed if not own guardian)* **Date**

Relationship to 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.** I consent to medical care if needed in an emergency, unless I check one of these boxes:
   - ☐ I have a religious or other objection to receiving medical treatment.
   - ☐ I consent to emergency medical care, but 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 participants (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 revise my information. I can ask to limit how my information is used.

7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

PARTICIPANT NAME: _____

PARTICIPANT SIGNATURE (required if over 18 years old and signing on own behalf)

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 if under 18 years old or has a legal guardian)

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

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Athlete Medical Form – **PHYSICAL EXAM**
(to be completed by a Medical Professional only)

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
- ☐ 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 Follow-up:

- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ Other/Exam Notes:
- ☐ 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

Name:

E-mail:

Licensed 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)

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