Special Olympics
MedFest®

Free Sports Physicals October 23!

All athletes need to have a physical exam before participating in sports. Take advantage of this FREE opportunity to obtain your sports physical!

This opportunity is open to all schools, students, athletes, and partners. Please join us!

- When: Monday, October 23, 2017, 10:30am-4:30pm
- Where: Lory Student Center, CSU, Fort Collins
  1101 Centre Ave Mall Fort Collins CO 80523
- Travel costs will be reimbursed, including bussing!

Be sure to bring the completed Medical History and Consent Form (pages 3-5 of this document) and the travel reimbursement form (page 2) with you to the event.

Register by completing the form below and sending to Leah Combs, Special Olympics Colorado, by October 13th: lcombs@specialolympicsco.org

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MedFest Registration Form

For Non-School Groups Only

Name: _____ Day-Of Contact Number: _____

E-Mail: _____

Number of Athletes: _____

Preferred Check-In Time* (between 12:30pm and 3:30pm): _____
*We will do our best to give you a check-in time during your preferred arrival request.

For Schools Only

School Name: _____ Teacher Name: _____

E-Mail: _____

Day-Of Contact Number: _____ Number of Students: _____

Preferred Check-In Time* (between 10:30am and 1:30pm): _____
*We will do our best to give you a check-in time during your preferred arrival request.

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October 23 MedFest Travel Reimbursement Form

Please complete and bring with you to the event.

Payable to: _____ Date: _____

Send to: _____ Amount: $ _____

Address: _____

_____

_____

_____

For mileage reimbursement of $0.40 per mile, please complete this portion (fuel receipts are not reimbursable).

Starting address: _____

Destination address: **Lory Student Center, 1101 Centre Ave. Mall, Fort Collins, CO 80523**

Any stops to pick up others:

_____

_____

_____

For bus or van rental reimbursement, please attach the invoice/receipt to this form, as well as any fuel receipts (fuel receipts are only reimbursed for rental vehicles).

Please submit this form at the MedFest event. Special Olympics Colorado will process the reimbursement request and if approved, issue a check within six weeks.

Athlete Medical Form – **HEALTH HISTORY**

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

Special Olympics

REGION/AREA:

DELEGATION/TEAM:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

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

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Eye color: Ethnicity: *(optional)*

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 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:

HAS THE ATHLETE 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 heart 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:**

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**

LAST NAME_____ FIRST NAME_____

RELEASE FORM

I, the undersigned, represent and warrant that, to the best of my knowledge and belief, I am/my child is/my ward is physically and mentally able to participate in Special Olympics Colorado. With my approval, licensed physicians is authorized to review the health information set forth in this application and administer a medical examination so as to certify that there is no medical evidence which would preclude me/my child/my ward from participation. I understand that if I/my child/my ward has Down Syndrome, I/he/she cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless a full radiological examination establishes the absence of Atlanto-axial instability. I am aware that the sports and events for which this radiological examination is required are judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift, snowboarding and soccer team competition. **Initial**_____

Special Olympics Colorado has my permission to use my/my child's/my ward's likeness, name, voice and words in television, radio, film, newspaper, magazines and any other media, and in any form, for the purpose of advertising or communicating the purpose and activities of Special Olympics Colorado and/or applying funds to support those purposes and activities. **Initial**_____

If a medical emergency should arise during my/my child's/my ward's participation in any Special Olympics Colorado activities and I am not able to give my consent, for whatever reason, I authorize Special Olympics Colorado to take whatever measures are necessary and which it deems advisable, to protect my/my child's/ my ward's health and well-being, including hospitalization. **Initial**_____

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact my local Area Manager if I have any questions about housing arrangements for a specific event or the housing policy in general. **Initial**_____

I acknowledge that Special Olympics requires each coach to pass an approved concussion awareness and safety recognition program and I have read the policy as posted on. www.specialolympicsco.org. **Initial**_____

I have read and fully understand the provisions of the above release and have explained the provisions to my child/ward. I understand that through my signature on this release form, I am agreeing to the above provisions on my own behalf or on the behalf of my child/ward, and hereby give my permission for my child/ward to participate in Special Olympics Colorado games, recreation programs and physical activities. **Initial**_____

Clearly Print Athlete Name_____

Signature of Adult Athlete/Parent/Caregiver_____ Date_____/_____/_____