

HEALTH INFORMATION UPDATE

TEAM NAME: _____ NUMBER: _____

Athlete's Social Security # _____ - _____ - _____ (if US Citizen) Male Date of Birth (month/day/year)
 Female _____ / _____ / _____

Athlete's Name _____

Athlete's Address _____

Athlete's Home Phone # (____) _____

City: _____ State: _____ Zip: _____

Parent Email Address _____

Parent/Guardian's Name _____

Parent Primary Phone # (____) _____

Parent/Guardian's Address (if different from athlete) _____

Parent Secondary Phone # (____) _____

Emergency Contact (if other than parent/guardian) _____

Parent Cell Phone # (____) _____

Primary Phone or Cell # (____) _____

Health/Accident Insurance Co. _____

Policy # _____

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Heart disease/heart defect/high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 15. Uses a wheelchair | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | 16. Allergy to the following | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Seizures/epilepsy/fainting spells | <input type="checkbox"/> | <input type="checkbox"/> | Medicine _____ | | |
| 4. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Foods _____ | | |
| 5. Concussion or serious head Injury | <input type="checkbox"/> | <input type="checkbox"/> | Insect Bites _____ | | |
| 6. Major surgery or serious illness | <input type="checkbox"/> | <input type="checkbox"/> | 17. Special Diet _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Blindness | <input type="checkbox"/> | <input type="checkbox"/> | 18. Exercise induced wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Asthma | <input type="checkbox"/> | <input type="checkbox"/> | 19. Tendency to bleed easily | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Down syndrome | <input type="checkbox"/> | <input type="checkbox"/> | 20. Emotional/psychiatric/behavior problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Has cervical spine (neck bone) x-rays been performed for Atlantoaxial Instability? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Serious bone or joint disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Parent/Sibling (under 40) died of heart disease | <input type="checkbox"/> | <input type="checkbox"/> | 22. Sickle cell trait or disease | <input type="checkbox"/> | <input type="checkbox"/> |
| NOTE: PHYSICAL EXAM PERFORMED BY A LICENSED EXAMINER REQUIRED FOR ATHLETES WITH YES IN ITEMS 1-10 | | | 23. Hearing aid/hearing loss | <input type="checkbox"/> | <input type="checkbox"/> |
| *11. Absence of one kidney or testicle | <input type="checkbox"/> | <input type="checkbox"/> | 24. Contact lenses/eyeglasses | <input type="checkbox"/> | <input type="checkbox"/> |
| *12. Heat stroke/exhaustion | <input type="checkbox"/> | <input type="checkbox"/> | 25. Dentures/false teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| *13. Impaired motor ability | <input type="checkbox"/> | <input type="checkbox"/> | 26. Immunizations (shots) up to-date | <input type="checkbox"/> | <input type="checkbox"/> |
| *14. Other problem that would interfere with sports participation | <input type="checkbox"/> | <input type="checkbox"/> | 27. Date of last tetanus shot | | |
| List: _____ | | | ____/____/____ | | |

***A NEW Special Olympics Kansas Medical/Release form must be completed by a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Physician's Assistant (PA) or an Advanced Registered Nurse Practitioner (ARNP).**

***NOTE: AN EXAM IS REQUIRED IF NEW PROBLEM IS CHECKED IN 11-14**

COMMENTS: _____

MEDICATIONS: Please print medication name, amount, date prescribed and number of times per day medication needs to be taken

Person completing form (normally parent/guardian or adult athlete) _____
Signature Date

IF HISTORY SIGNED BY ADULT ATHLETE – I have reviewed the health history with the athlete whose signature appears above

Signature Date Relationship to athlete

*IMPORTANT: If there is any significant change in the athlete's health, the athlete's condition should be reviewed by a licensed examiner before further participation