C.A.M.P. UNIVERSITY

Can Achieve Maximum Potential

Dear Prospective C.A.M.P. University Family:

We at C.A.M.P. University take a deep interest in ensuring that we can satisfactorily meet the needs of candidates who are being considered for admission to our Day Program. We want our CAMPers to have a fun and enjoyable experience. We appreciate the time and effort needed to complete this application, and we are always willing to help you through this process should you require assistance. If you have any questions, please contact C.A.M.P. University at 956-800-5292.

Please return the completed application along with the required documents to C.A.M.P. University at 4200 N. Main St. in McAllen. After we have received these materials, our Admissions Committee will review the information and determine the suitability and placement of the potential candidate as a member of C.A.M.P. University. Once the application is reviewed we'd like to invite your student to attend C.A.M.P. University for three days as our guest. Please call our office at 956-800-5292 to make arrangements.

Thank you for your interest in C.A.M.P. University. We hope that we can be of service to you.

Sincerely,

Abbie Sasser
C.A.M.P. University Founder and Board Member

C.A.M.P. University does not discriminate on the basis of race, color, ethnicity, religion, age, or gender in its admissions policies or programs.

C.A.M.P. University Admission Documents Checklist

Please include the following documents*:*

- ❑ Completed Admission Application
  Date turned in to office: _____

- ❑ Current psychological evaluation from High School records (if available)
  (Wechsler Intelligence Scale, Vineland Testing, etc.)

- ❑ Current medical physical (Special Olympics Athletic Medical Form and a current TB skin test or chest x-ray)
  *Please note: we require the physical to be redone every three years whether or not your loved one participates in Special Olympics. This is for their safety.

- ❑ Current list of medications

- ❑ Immunization Records (if possible)

- ❑ Completed Signature on:
  Photo use consent form
  Parental consent waver form for field trips
  Hold harmless agreement
  Transportation liability release form

- ❑ Completed authorization form for background check (Please have you driver's license and social security card so we can make a copy for the background check.)

- ❑ Completed automatic draft form

For Office Use Only

Dates of trial days: _____

Date of director and board approval: _____

C.A.M.P. UNIVERSITY

Application for Admission

(Please Print or Type)

Date: _____ Desired Date of Admission: _____

Past involvement with C.A.M.P. University _____

_____

How did you become aware of C.A.M.P. University? _____

_____

Candidate Information

Name: _____

Phone: _____

Address:_____

Date of Birth: _____ Place of Birth: _____

Social Security Number (last four digits) __ __ __ __

Gender: _____ Race: _____ Height: _____ Weight: _____

Primary language: _____ Secondary language(s): _____

Diagnosis (es):_____

_____

Briefly describe any physical disabilities or limitations that the admissions candidate may have:

_____

_____

Candidate's desired areas for improvement: _____

_____

Candidate's personal goals: _____

_____

_____

_____

Sponsor's goals/expectations for the candidate: _____

_____

_____

_____

Parent/Guardian Contact Information

Name: _____ _____

Home Phone: _____ Business Phone: _____

Business Address: _____ _____

Email: _____

Home Address: _____

Relationship to Candidate: _____

Employer: _____

Title: _____

Emergency Contact Information

Primary Contact: _____

Home Phone: _____

Business Phone: _____

E-mail: _____

Relation to Candidate: _____

Mailing Address: _____

Secondary Contact: _____

Home Phone: _____

Business Phone: _____

E-mail: _____

Relationship to Candidate: _____

Mailing Address: _____

Optional Family Information (e.g. relationship concerns, frequency of contact, etc.):

_____

_____

_____

Candidate's Educational and Residential History

Please indicate each type of educational program in which the candidate has participated and provide the details for each in the spaces below. Elaborate as needed to illustrate achievements or to identify areas for improvement. Continue on additional sheets if necessary.

Educational Background

1. Name of school or program _____

Dates/years attended _____

If candidate is not currently enrolled in this program, please explain the reason for leaving.

_____

_____

Briefly describe the candidate's overall educational experience with this program (strengths, areas for improvement, grades, etc.). _____

_____

_____

2. Describe candidate's formal education and any trade, technical, or vocational training: _____

_____

Employment History

Please complete this section of the application to describe all past employment by the candidate.

1. Employer's name: _____

Job/duties performed: _____

_____

Dates of employment: _____

Reasons for leaving: _____

2. Employer's name: _____

Job/duties performed: _____

_____

Dates of employment: _____

Reasons for leaving: _____

If the candidate has not had a job, please let us know if they received any job skills training in school.

_____

_____

_____

_____

What is the candidate's dream job?

_____

_____

_____

_____

_____

_____

Candidate's Health

Please list the types of medical coverage that the candidate has and provide the corresponding policy numbers (Insurances, Medicaid, Medicare, VA, etc.):

Name of Provider	Policy Number	Expiration/Renewal Date
_____	_____	_____
_____	_____	_____

Name of Candidate's Primary Care Physician: _____

Physician's Phone: _____

Address:_____

Special dietary needs:

_____

_____

Seizures:

Does the candidate have a history of seizures? □ yes □ no

If **yes**: Type of seizures (grand mal, petit mal, other): _____

Date of 1st seizure: _____ Date of most recent seizure: _____

Seizure frequency: □ daily □ weekly □ monthly □ semi-annually □ other

Are the seizures suppressed or controlled by prescribed medication(s)? □ yes □ no

Please list any limitations or risks that may result from a seizure: _____

_____

_____

Candidate's Medical History

Please examine the list below and note candidate's experiences with any of these factors or conditions. If possible, note the year of occurrence and elaborate briefly on the severity or frequency of the condition.

Circle one		Condition	Year(s)	Additional Description
yes	no	Speech disorders		
yes	no	High blood pressure		
yes	no	Heart problems		
yes	no	Diabetes		
yes	no	Cancer		
yes	no	Stroke		
yes	no	Kidney disease		
yes	no	Glaucoma		
yes	no	Arthritis		
yes	no	Sinus problems		
yes	no	Headaches		
yes	no	Hearing problems		
yes	no	Asthma		
yes	no	Digestive problems		
yes	no	Fainting		
yes	no	Balance problems		
yes	no	Menstrual problems		
yes	no	Muscular problems		

Circle one		Condition	Year(s)	Additional Description
yes	no	Polio		
yes	no	Pneumonia		
yes	no	Anemia		
yes	no	Chicken pox		
yes	no	Mumps		
yes	no	High cholesterol		
yes	no	Measles		
yes	no	Pregnancy		
yes	no	Hepatitis		
yes	no	Thyroid problems		
yes	no	Venereal disease		
yes	no	Swallowing difficulty		
yes	no	Head injury		
yes	no	Depression		
yes	no	Use of prosthetics, canes, walkers, lifts, and other devices		

Other significant health concerns: _____

_____

_____

Candidate's Religious Affiliations *(optional)*

Church/denominational preference: _____

Other religious interests/activities: _____

Candidate's Leisure and Recreation Interests

Hobbies:_____

Past Special Olympics activity:_____

_____

Level of participation in the sports listed above: _____

_____

Assistance/Guidance needed for any recreational activities: _____

_____

Favorite forms of entertainment: _____

_____

Personal and Social Development

Reading, speaking, listening strengths: _____

_____

Reading, speaking, listening limitations: _____

_____

Does the candidate socialize well with others?_____

How does he/she handle disagreements? _____

_____

Does the candidate have a history of aggression or threatening physical or verbal behavior?

□ yes □ no If yes, please explain the frequency of this behavior, the possible causes/ environmental triggers, and the consequences of such activity. _____

_____

_____

Does the candidate feel remorse for his/her aggressive or threatening behavior? _____

_____

Activities of Daily Living

Can the candidate perform the following activities independently? If no, please include the level of assistance required (if applicable).

Mobility/ambulation: _____

_____ __

Communicating needs: _____

_____ __

Personal grooming and dressing: _____

_____ __

Orientation/Disorientation: _____ __

_____ __

Bowel and Bladder management: _____ __

_____ __

Eating: _____

_____ __

Social Étiquette (table manners/politeness) _____

_____ __

Awareness of time/day (clocks/calendars): _____ __

_____ __

Use of public transportation: _____ __

_____ __

Cooking: _____ __

_____ __

Laundry and house cleaning: _____ __

_____ __

Managing personal finances: _____ __

_____ __

Guardianship Statement

Complete either Section I or Section II below:

Section I

Attached is a copy of a court-executed guardianship order declaring _____

_____ to be the lawful guardian(s) of

_____.

_____ _____

Guardian/Sponsor Printed Name Candidate Printed Name

_____ _____

Guardian/Sponsor Signature & Date Candidate Signature / Date

Section II

I know of no court-executed guardianship order for _____.

_____ _____

Guardian/Sponsor Printed Name Candidate Printed Name

_____ _____

Guardian/Sponsor Signature & Date Candidate Signature / Date

Affirmation of Completeness and Accuracy of Application

Guardian/Sponsor: After you have provided the above information, please read the following statement and sign where indicated:

I/We, _____, hereby affirm that the information provided within the completed application is complete and accurate to the best of my/our knowledge.

_____ _____

Guardian/Sponsor Printed Name Candidate Printed Name

_____ _____

Guardian/Sponsor Signature and Date Candidate Signature and Date (if appropriate)

C.A.M.P. UNIVERSITY

Transportation Liability Release Form

I, _____, being 21 years of age or older, do for myself and do hereby release, forever discharge and agree to hold harmless

(Name of Group) C.A.M.P. University and (**Trip Organizer)** C.A.M.P. University Staff

Transportation Volunteers

and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damages and expenses, of any nature whatsoever which may be incurred by the undersigned that occur while said is participating in the above described transportation services, trip or activity.
Furthermore, I hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and any related activities involved therein.
The undersigned further hereby agrees to hold harmless and indemnify said organization(s), its directors, employees and agents, for any liability sustained by said travel organizers as the result of negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

Participant Signature

_____

Trip Participant Acknowledgement

I was provide and have read the above and understand the Rules of Conduct and will fully abide by them, as well as all additional instructions of the leadership of this trip, and activity directors.

This agreement is for any and all field trips organized by C.A.M.P. University

_____

_____

Parent or Legal Guardian

C.A.M.P. UNIVERSITY

Parental Consent & Waiver form for Field Trips

Permission is granted or my son/daughter to participate in the following field trip with C.A.M.P. University
Name: _____

I/We, hereby acknowledge that sufficient information has been provided by the C.A.M.P. University School with respect to planned activity, duration, location, method of transportation, participants and supervision.

I/We, hereby acknowledge that certain RISKS OF INJURY are inherent to participate in learning activities outside the school. These types of injuries may be minor or serious and may result from one's actions, or the actions or inaction of others, or a combination of both.

I/We understand that the Rules and Regulation established for the field trip are designed for the safety and protection of the participants and herby undertakes to inform my child to abide by these rules and regulations.

I/We understand that:

1. A minimum level of fitness and health (physical, mental and emotional), is required
2. Each person has a different capacity for participation: and
3. Any exceptions to full participation are identified on the Child Health Form.

I/We declare having read and understood the above Parental Consent Agreement in its entirely and hereby consent to allow my/our young adult to participate, acknowledging all of the foregoing.

_____	_____	_____
Parent or Legal Guardian Signature	**Date**	**Phone Number**

_____	_____
Emergency Contact	**Phone Number**

C.A.M.P. UNIVERSITY

Hold Harmless Agreement

The following named is a participant in C.A.M.P. University, (I, We) agree to hold C.A.M.P. University harmless from any losses to the participant or family member, physical, mental or financial which claims could arise at any time or place C.A.M.P. University has an activity or as a result of any activity or meeting.

It is further understood that C.A.M.P. University is to be held harmless for any and all claims which could be entered for sexual abuse and or sexual harassment as a result of activities or meeting associated with C.A.M.P. University.

It is further agreed that this document may be amended or replaced upon the direction for Insurance Company providing insurance protection for C.A.M.P. University.

In the event of any legal claim being filed against C.A.M.P. University by any participant or family member, current or past, C.A.M.P. University, its coordinator, and its board of director will be held harmless, leaving the claimant to pay any and all expenses which may arise for any legal action.

Signed for Participant

_____	_____	_____
Parent or Legal Guardian (circle one)	C.A.M.P. University Participant	Date

C.A.M.P. UNIVERSITY

C.A.M.P. University Members
Photo Use Consent Form

I, _____, give C.A.M.P. University permission to use
Parent or Legal Guardian

photos, and/or videos of _____ for public
C.A.M.P. University Participant

relation purposes on but not limited to: news articles, brochures, newsletters, social media, and/or presentations showing C.A.M.P. University activities to prospective new members, their families, or to prospective donors.

Signed for Participant

_____	_____	_____
Parent or Legal Guardian	C.A.M.P. University Participant	Date

Background Check Consent

AUTHORIZATION/CONSENT FOR EMPLOYMENT

NAME:		DATE OF BIRTH:
DRIVER LICENSE NUMBER:	STATE OF LICENCE ISSUED:	SOCIAL SECURITY NUMBER:

In consideration of my contract/employment, I understand and agree:

1. I will be required to provide legal proof of authorization to work in the United States of America.
2. My record for criminal conviction will be checked through the Texas Department of Public Safety annually. I understand that it is my responsibility to report any current or future arrests, indictments, deferred adjudication, and convictions for any offenses to the Executive Director.
3. The requirement related to the pre-contract screening for client abuse, neglect, and exploitation will be completed annually. (Nurses aid and Employee Misconduct Registries)
4. I certify that all the information provided by me in connection with my application is true and correct. Any misstatement or omission of fact shall be considered cause for termination of contract/employment.
5. I acknowledge that all medical, financial and personal information is confidential and protected against unauthorized viewing, discussion, and disclosure. Furthermore, it is my responsibility to protect the privacy and confidentiality of client information. I also understand that unauthorized use or disclosure of such information will result in disciplinary action.

_____ _____

Signature Date

C.A.M.P. UNIVERSITY

Automatic Draft Form

Family Information(required) Please Print in Capital Letters

Student Name : _____ Phone #: _____

DOB: _____ Email: _____

Parents or Checking Account Holder (Please write below)

Name:_____ Street Address:_____

City:_____ State:_____ County: _____

Authorization Agreement for Automatic Draft

I hereby authorize **Camp University** to initiate automatic withdrawals from my account at the financial institution named below. Monthly Payment of: __$_____

Further, I agree not to hold **Camp University** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Camp University** receives a written notice of cancellation from me or my financial institution.

Please Select One Payment Option Listed Below

A. ( ) I want you to Transfer Payments Monthly from my Bank Account

Please keep this receipt for future reference

Account Information

Name of Financial Institution: _____

Routing Number : ___ ___ ___ ___ ___ ___ ___ ___ ___ **(9 numbers)**

Account Number: o Checking o Savings

Signature

Authorized Signature: **Date:**

B. ( ) I want you to Transfer Payments Monthly from My Credit Card

Account Information

Credit Card Account #:

Expiration Date: _____ / _____ **3 Digit Code (on the back of card)**_____

Credit Card Type: **Visa** ___ **MasterCard** ___ **Discover** ___ **Amex** ___

Signature

Authorized Signature: **Date:**

Physical and Medication Records

The following pages are required medical information for both C.A.M.P. University and Special Olympics. They are required for your loved one's safety whether or not they choose to participate in Special Olympics. We do require them to be updated every three years so that we can make accommodations as needed for your loved one and help them in the unlikely event of an emergency.

A parent or guardian can fill out the first four pages. A doctor must fill out the last two pages. Please be sure that the doctor signs and dates their forms.

The completed forms must be turned in at least eight weeks prior to a Special Olympics event for your loved one to be eligible to participate in that event.

Please fill out the medication list with all current medications only and let us know when a medication has changed so the list can be updated. Include any medications that are taken at home. In the event of an emergency we would need to let paramedics know what medications are taken and basic medical history. **Please keep medical forms updated.**

All information is kept confidential and under lock and key.

Please let us know if you have any questions about these forms.

ATHLETE REGISTRATION FORM

Special Olympics

State Special Olympics Program:_____

Are you a new athlete to Special Olympics or Re-Registering? ☐ New Athlete ☐ Re-Registering

ATHLETE INFORMATION		
First Name:	**Middle Name:**	
Last Name:	**Preferred Name:**	
Date of Birth (mm/dd/yyyy):	☐ Female ☐ Male	
Race/Ethnicity (Optional): ☐ American Indian/Alaskan Native ☐ Asian ☐ Two or More Races ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Hispanic or Latino (specific origin group:_____)		
Language(s) Spoken in Athlete's Home (Optional): Check all that apply ☐ English ☐ Spanish ☐ Other (please list):		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? ☐ Yes ☐ No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
☐ **Same Contact Info as Athlete**		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
EMERGENCY CONTACT INFORMATION		
☐ **Same as Parent/Guardian**		
Name:		
Phone:	**Relationship:**	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

ATHLETE RELEASE FORM

Special Olympics

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
   - ☐ I have a religious or other objection to receiving medical treatment. (Not common.)
   - ☐ I do not consent to blood transfusions. (Not common.)

   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
   - I agree and consent to Special Olympics:
     - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
     - using my personal information and creating a profile of me for communications and marketing purposes, including direct digital marketing through email, SMS, social media, and other channels.
     - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
   - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
   - *Sharing of Personal Information.* Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy_Policy.aspx.

Athlete Name:	**E-mail:**
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks 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:**

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Special Olympics

Athlete First & Last Name:_____ **Preferred Name:**_____

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

STATE PROGRAM:_____ **E-mail:**_____

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

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ Other Syndrome, please specify:_____

ALLERGIES & DIETARY RESTRICTIONS

☐ No Known Allergies
☐ Latex
☐ Medications:_____
☐ Insect Bites or Stings:_____
☐ Food:_____

ASSISTIVE DEVICES - 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

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?
☐ No ☐ Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

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, describe date and results*
☐ Yes, had abnormal EKG
☐ Yes, had abnormal Echo

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

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

*If yes, list seizure type:*_____

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

MENTAL HEALTH

Self-injurious behavior during the past year	☐ No	☐ Yes	**Depression** *(diagnosed)*	☐ No	☐ Yes
Aggressive behavior during the past year	☐ No	☐ Yes	**Anxiety** *(diagnosed)*	☐ No	☐ Yes

Describe any additional mental health concerns:

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**

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)

Athlete's First and Last 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				

If female athlete, list date of last menstrual period:_____

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

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

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

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

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

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

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

Athlete Medical Form – **PHYSICAL EXAM**

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name:_____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

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

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		Bowel Sounds	☐ Yes	☐ No
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		Hepatomegaly	☐ No	☐ Yes
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		Splenomegaly	☐ No	☐ Yes
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		Abdominal Tenderness	☐ No	☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	Kidney Tenderness	☐ No	☐ Right ☐ Left
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	Right upper extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Oral Hygiene	☐ Good	☐ Fair	☐ Poor		Left upper extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Thyroid Enlargement	☐ No	☐ Yes			Right lower extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Lymph Node Enlargement	☐ No	☐ Yes			Left lower extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		Abnormal Gait	☐ No	☐ Yes, describe below
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		Spasticity	☐ No	☐ Yes, describe below
Heart Rhythm	☐ Regular	☐ Irregular			Tremor	☐ No	☐ Yes, describe below
Lungs	☐ Clear	☐ Not clear			Neck & Back Mobility	☐ Full	☐ Not full, describe below
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		Upper Extremity Mobility	☐ Full	☐ Not full, describe below
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		Lower Extremity Mobility	☐ Full	☐ Not full, describe below
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R		Upper Extremity Strength	☐ Full	☐ Not full, describe below
Cyanosis	☐ No	☐ Yes, describe			Lower Extremity Strength	☐ Full	☐ Not full, describe below
Clubbing	☐ No	☐ Yes, describe			Loss of Sensitivity	☐ No	☐ Yes, describe below

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

OR

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

ATHLETE CLEARANCE TO PARTICIPATE (*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 needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions.**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe →** _____

☐ **This athlete MAY NOT participate in Special Olympics sports at this time & 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 (but not required) 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:
	E-mail:
Signature of Licensed Medical Examiner Exam Date	Phone: License #:

Athlete Medical Form – **MEDICAL REFERRAL FORM**

(To be completed by a Licensed Medical Professional only if referral is needed)

Athlete's First and Last Name:_____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:_____

Specialty:_____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

☐ 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:

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

☐ **Yes** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **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

Medication Record

Name of CAMPer: _____

Date Perscribed	Date Stopped	Medication	Dosage	Frequency (i.e. 2x per day)	Time	AM / PM	Reason

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C.A.M.P.
UNIVERSITY

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Medical Diagnosis Form

Name of Patient:_____

Physician:_____Physician's Phone:_____

Physician's Address:_____City/State/Zip_____

This patient has (check all that apply) ( )Autism ( )Down Syndrome ( )Fragile X Syndrome
( )Cerebral Palsy ( )Fetal Alcohol Syndrome
( )Other syndrome (*please specify*): _____

Medical Examiner Sign and Date
Signature of Licensed Physician, Physician's Assistant licensed by State Board of Physicians Assistant Examiners, or Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.

_____Date_____

_____
Printed Name

_____
License

_____
Phone

Page to be completed by medical examiner