

MID-AMERICA GAMES FOR THE DISABLED, INC.
Athlete Participation Health Form

Date: _____ USA Boccia # _____

Name: _____ Date of Birth: _____

Address: _____ Gender: _____ Female _____ Male

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Team Affiliation: _____ Social Security #: _____

Insurance Company: _____ Policy Number: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Alt. Number: _____

Primary Disability: _____ Cerebral Palsy _____ Traumatic Brain Injury _____ Stroke _____ Spina Bifida _____ Other

Cause of Disability: _____ Congenital (Present at Birth) _____ Acquired

If acquired, please complete the following: Date of Onset: _____

_____ Encephalitis/Meningitis/Infection _____ Gun Shot _____ Drug/Poisoning _____ Near Drowning

_____ Motor Vehicle Accident _____ Other: _____

Disability Related Problems: (Check all that apply)

_____ Hearing Impairment _____ Learning Disability _____ Perceptual Motor Problems

_____ Visual Impairment _____ Speech and Language Involvement

List All Past Surgeries (Procedure & Date): _____

List Any Significant Injuries with Date of Occurrence: _____

Medications You Are Currently Taking (Prescription & Over the Counter): _____

Medical History:

Date of Last Tetanus Shot: _____

High Blood Pressure: _____ No _____ Yes Heart Disease: _____ No _____ Yes

Asthma/Lung Disease: _____ No _____ Yes Bladder Problems: _____ No _____ Yes

Seizures: _____ No _____ Yes

Type: _____

Number in Past 12 Months: _____ Date of Last Seizure: _____

Diabetes: _____ No _____ Yes If yes, are you insulin dependent? _____

Allergies: _____ No _____ Yes If yes, explain: _____

Above Conditions Affect Sports Participation: _____ No _____ Yes Explain: _____

Sports Classification: _____ Boccia _____ Bowling

Permission is given to Mid America Games, its representative, a representative of the local team, or local competition organizing committee to seek medical care in case of emergency for the above person.

Signature of participant or parent/guardian if under 18

Date

COMPLETE BOTH SIDES

MID-AMERICA GAMES FOR THE DISABLED, INC.
Athlete Pre-Participation Health Form Continued

TO BE COMPLETED BY A LICENSED PHYSICIAN

Athlete's Name: _____

Diagnosis/Disability (List All): _____

Impairments (Eg. Hemiparesis, etc.): _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____ Sex: _____

Physical Exam:	Normal	Abnormal	Explanation of Abnormalities
Head/Neck	_____	_____	_____
Eyes/Vision	_____	_____	_____
Ears/Hearing	_____	_____	_____
Heart/Lungs	_____	_____	_____
G.U.	_____	_____	_____
C.N.S.	_____	_____	_____
Skin	_____	_____	_____

Orthopedic Exam:

ROM Loss/Contractures: _____

Joint Laxity/Instability: _____

Other: _____

Significant "Abnormal Tests": EKG/X-Ray/Lab: _____

Approval for Participation: _____ Yes _____ No

Comments/Restrictions: _____

Referral For Further Evaluation: _____

Physician's Signature: _____ Date: _____

Print Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

COMPLETE BOTH SIDES