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

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: ______________