



**Special Olympics**  
 Pennsylvania  
 Montgomery County

# Special Olympics Montgomery County

## Medical Update

**THIS FORM & A COPY OF THE ATHLETES INSURANCE CARD  
 MUST BE HANDED IN THE FIRST WEEK OF PRACTICE**

Athlete's Name \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address, City, State, Zip \_\_\_\_\_

**Insurance Information MUST be filled in. Please Provide a COPY of Athlete's Insurance Card.**

Insurance Co. \_\_\_\_\_

Policy Number \_\_\_\_\_

<u>Medication</u>	<u>Dosage</u>	<u>Amount/Time</u>	<u>Reason</u>

No Medications of ANY kind (prescription or over-the-counter) will be given unless specified above.

Is permission given to administer Tylenol, if needed: (yes or no) \_\_\_\_\_

Is Athlete self-medicating? (yes or no) \_\_\_\_\_

Is Athlete knowledgeable about medications? (yes or no) \_\_\_\_\_

Does the Athlete have allergic reactions to anything. Medications, bee stings, food, etc. (yes or no) \_\_\_\_\_

Please state allergy \_\_\_\_\_

Family/Caregiver concerns \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

**This Completed Form and a copy of the Athlete's Insurance Card Must Be Returned on the first Day of Practice  
Complete the following if athlete has seizures. If athlete does not have seizures please note with "N/A"**

Athlete's Name \_\_\_\_\_

Type of seizure \_\_\_\_\_ Frequency \_\_\_\_\_

Date of last seizure \_\_\_\_\_ Length of Seizure \_\_\_\_\_

Describe usual characteristics of seizure \_\_\_\_\_  
\_\_\_\_\_

Indicate each of the following as:

**A: Always**

**S : Sometimes**

**N : Never**

\_\_\_\_\_ Falls to floor

\_\_\_\_\_ Loss of response

\_\_\_\_\_ Clenched jaw

\_\_\_\_\_ Abnormal eye movement

\_\_\_\_\_ Lips pale

\_\_\_\_\_ Rigid trunk, arms and legs

\_\_\_\_\_ Lips blue

\_\_\_\_\_ Difficult to arouse after seizure

\_\_\_\_\_ Frothy saliva

\_\_\_\_\_ Jerking movements of arms and legs

Describe activity that appears to precipitate seizure \_\_\_\_\_  
\_\_\_\_\_

Describe actions to be taken if your athlete has a seizure \_\_\_\_\_  
\_\_\_\_\_

Describe athlete's activity level after a seizure \_\_\_\_\_  
\_\_\_\_\_

Do you wish to have an ambulance called immediately in the event your athlete has a seizure?  
\_\_\_\_\_

If there is any evidence of respiratory distress or injury or if the seizure lasts more than 5 minutes, an ambulance will be automatically called. In the event an ambulance is called to the scene, the Athlete/Parent's primary insurance carrier will be billed. Whatever is not covered can then be submitted for coverage through Special Olympics insurance.

Athlete's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Athlete's Neurologist \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_