

# Special Olympics North Dakota 6-Month Medical Extension – Form B

DATE \_\_\_/\_\_\_/\_\_\_ Name \_\_\_\_\_ Age \_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_

Phone \_\_\_\_\_ Date of Last Physical Exam \_\_\_/\_\_\_/\_\_\_

**Check** Yes or No boxes for each question or **Circle** question numbers for which you cannot answer.

**IN THE LAST YEAR, since your last complete Exam with your physician, HAVE YOU HAD ANY CHANGES TO THE FOLLOWING QUESTIONS:**

**Athlete Health Questionnaire**

*Over the past 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

**(If the sum of responses to questions 1 & 2 or 3 & 4 are primarily 3, please see your provider)**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>YES</b>               | <b>NO</b>                |
| 1. In the last year, has a doctor restricted your participation in sports for any reason without clearing you to return to sports? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**IMPORTANT health questions about YOU in 2020/21**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 2. In the last year, have you passed out or nearly passed out <i>during or after</i> exercise? .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the last year, have you had discomfort, pain, tightness, or pressure in your chest during exercise? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the last year, does your heart race or skip beats (irregular beats) during exercise? .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the last year, do you get light-headed or feel more short of breath than expected during exercise? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the last year, have you had an unexplained seizure? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**Important heart health questions about your family in 2020/21**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 7. In the last year, has anyone in your immediate family died suddenly and unexpectedly for no apparent reason? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In the last year, has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before the age 35 (including an unexplained drowning or an unexplained car accident)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the last year, has anyone in your immediate family had instances of unexplained fainting, seizures, or near drowning? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. In the last year, has anyone in your immediate family been diagnosed with hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long or short QT Syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. In the last year, has anyone in your immediate family under age 35 had a heart problem, pacemaker, or implanted defibrillator? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**MEDICAL RISK QUESTIONS IN THE LAST YEAR**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 12. In the last year, have you had a head injury or concussion that still has symptoms like continuing headaches, concentration problems or memory problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had or been diagnosed with the coronavirus, specifically COVID-19 .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**Please list any health concerns, all medications, allergies, or medical conditions**

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I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities.

Parent or Legal Guardian Signature \_\_\_\_\_ Athlete Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

[Type here] SOND ACCEPTED: \_\_\_\_\_ SOND NOT ACCEPTED: \_\_\_\_\_ REQUIRES FOLLOW: \_\_\_\_\_