Central Maine Adaptive Sports

Athlete Medical Form

(To be completed by a medical professional who cares for the athlete)

Athlete Full Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: _____

Full Address: _____

Phone: _____ Email: _____

Primary Disability: _____

Additional Diagnoses: _____

ALLERGIES & DIETARY RESTRICTIONS	ASSISTIVE DEVICES - Does the athlete use *(check any that apply)*:		
☐ No Known Allergies	☐ Brace	☐ Colostomy	☐ Communication Device
☐ Latex	☐ C-PAP Machine	☐ Crutches or Walker	☐ Dentures
☐ Medications:	☐ Glasses or Contacts	☐ G-Tube or J-Tube	☐ Hearing Aid
☐ Insect Bites or Stings:	☐ Implanted Device	☐ Inhaler	☐ Pacemaker
☐ Food:	☐ Removable Prosthetics	☐ Splint	☐ Wheel Chair

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*

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 CMAS adaptive sports without restrictions.**

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

☐ **This athlete MAY NOT participate in CMAS adaptive 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:

Signature of Licensed Medical Examiner Exam Date

Name:

E-mail:

Phone: License #: