



ATHLETE MEDICAL FORM - PAGE 2

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer).

Yes No

- Has an x-ray evaluation for atlanto-axial instability been done?
- If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Blood pressure: ____/____ Weight: ____ Height: ____

Normal/Abnormal

Normal/Abnormal

Normal/Abnormal

- | | | |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Vision | <input type="checkbox"/> <input type="checkbox"/> Cardiovascular system | <input type="checkbox"/> <input type="checkbox"/> Cranial nerves |
| <input type="checkbox"/> <input type="checkbox"/> Hearing | <input type="checkbox"/> <input type="checkbox"/> Respiratory system | <input type="checkbox"/> <input type="checkbox"/> Coordination |
| <input type="checkbox"/> <input type="checkbox"/> Oral cavity | <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal system | <input type="checkbox"/> <input type="checkbox"/> Reflexes |
| <input type="checkbox"/> <input type="checkbox"/> Neck | <input type="checkbox"/> <input type="checkbox"/> Genitourinary system | |
| <input type="checkbox"/> <input type="checkbox"/> Extremities | <input type="checkbox"/> <input type="checkbox"/> Skin | |

Other: _____

Primary MR Etiology/Category: (If known) _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

EXAMINER S SIGNATURE: _____ Date ____/____/____

EXAMINER S NAME: _____

ADDRESS: _____

PHONE: _____