



### ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

|   |     |    |
|---|-----|----|
| 1. Type of disability:  |     |    |
| 2. Date of disability:  |     |    |
| 3. Classification (if available):   |     |    |
| 4. Cause of disability (birth, disease, injury, or other):  |     |    |
| 5. List the sports you are playing:   |     |    |
|   | Yes | No |
| 6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?              |     |    |
| 7. Do you use any special brace or assistive device for sports?   |     |    |
| 8. Do you have any rashes, pressure sores, or other skin problems?  |     |    |
| 9. Do you have a hearing loss? Do you use a hearing aid?  |     |    |
| 10. Do you have a visual impairment?  |     |    |
| 11. Do you use any special devices for bowel or bladder function?   |     |    |
| 12. Do you have burning or discomfort when urinating?   |     |    |
| 13. Have you had autonomic dysreflexia?   |     |    |
| 14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness? |     |    |
| 15. Do you have muscle spasticity?  |     |    |
| 16. Do you have frequent seizures that cannot be controlled by medication?                                      |     |    |

Explain "Yes" answers here:

\_\_\_\_\_  
\_\_\_\_\_

Please indicate whether you have ever had any of the following conditions:

|  | Yes | No |
|--|-----|----|
| Atlantoaxial instability                                     |     |    |
| Radiographic (x-ray) evaluation for atlantoaxial instability |     |    |
| Dislocated joints (more than one)                            |     |    |
| Easy bleeding  |     |    |
| Enlarged spleen  |     |    |
| Hepatitis  |     |    |
| Osteopenia or osteoporosis                                   |     |    |
| Difficulty controlling bowel                                 |     |    |
| Difficulty controlling bladder                               |     |    |
| Numbness or tingling in arms or hands                        |     |    |
| Numbness or tingling in legs or feet                         |     |    |
| Weakness in arms or hands                                    |     |    |
| Weakness in legs or feet                                     |     |    |
| Recent change in coordination                                |     |    |
| Recent change in ability to walk                             |     |    |
| Spina bifida   |     |    |
| Latex allergy  |     |    |

Explain "Yes" answers here:

\_\_\_\_\_  
\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_