

**HONG KONG, CHINA SPORTS ASSOCIATION FOR PERSONS WITH INTELLECTUAL DISABILITY  
SPECIAL OLYMPICS HONG KONG**

**MEDICAL CERTIFICATION FORM**

Official Use :

NAME OF ATHLETE:

\_\_\_\_\_ (in Chinese) \_\_\_\_\_ (in English)

SEX: \_\_\_\_\_ BIRTH DATE: D \_\_\_\_ M \_\_\_\_ Y \_\_\_\_

ORGANIZATION: \_\_\_\_\_

Approximate date of last physical examination: \_\_\_\_\_

Recent  
Photo

**PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Vision: \_\_\_\_\_ OD: \_\_\_\_\_ OS: \_\_\_\_\_ Glasses/Contacts: YES ( ) NO ( )

List any metabolic disorders and special diets needed, if any \_\_\_\_\_

	<u>Normal</u>	<u>Abnormal</u>	<u>Diagnosis &amp; Recommendation</u>
Eyes	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Throat	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Extremities	_____	_____	_____
Neurological	_____	_____	_____

Allergies: YES ( ) NO ( ) List \_\_\_\_\_

Hernia: YES ( ) NO ( ) Date of last Tetanus Toxoid \_\_\_\_\_

History of seizures: YES ( ) NO ( ) If yes, type(s) \_\_\_\_\_

Will athlete require medication during Hong Kong, China Sports Association for Persons with Intellectual Disability (HKSAPID) & Special Olympics Hong Kong (SOHK) activities? YES ( ) NO ( ) If yes, please complete:

Name of Medication	Exact Dosage	Intervals (Given How Often)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Restrictions, if any \_\_\_\_\_

I have examined \_\_\_\_\_ and in my opinion, there is/is not\* mental or physical reason why he/she should not participate in the HKSAPID & SOHK Programs. Further information will be forwarded, if required. Special medication, if any, is specified in this application.

\*Please delete as appropriate

For more information on the Association's guideline for the use of personal data, please visit the Association's Personal Information Collection Statement.

Doctor's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

**Form D** Medical Certification Form