

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

Application expires 3 years from signature date of Examiner.

## DEMOGRAPHICS

PROGRAM \_\_\_\_\_

Athlete's Name \_\_\_\_\_

Athlete's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent / Guardian's Name \_\_\_\_\_

Parent / Guardian's Address (if different than athlete) \_\_\_\_\_

Emergency Contact (if other than parent / guardian) \_\_\_\_\_

Health / Accident Insurance Company \_\_\_\_\_

Male     Female

Date of Birth (month / day / year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Ethnicity \_\_\_\_\_

Athlete Home Phone No. \_\_\_\_\_

Parent Primary Phone No. \_\_\_\_\_

Parent Secondary Phone No. \_\_\_\_\_

Parent E-mail \_\_\_\_\_

Emergency Phone No. \_\_\_\_\_

Policy No. \_\_\_\_\_

## HEALTH HISTORY: TO BE COMPLETED BY PARENT / CAREGIVER

<table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Down Syndrome</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Chest pain</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Seizures / epilepsy / fainting spells</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Diabetes</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Concussion or serious head injury</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Major surgery or serious illness</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Heat stroke / exhaustion</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Heart disease / heart defect / high blood pressure</p>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Blindness / visual problem</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Contact lenses / glasses</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Bone or joint problem</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Allergy:</p> <p>Medicines: _____</p> <p>Food: _____</p> <p>Insect stings / bites: _____</p>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr><td>Yes</td><td>No</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Special diet</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Asthma</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Tobacco use</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Emotional / psychiatric / behavioral</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Sickle cell trait or disease</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Immunizations up to date</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Other (For additional space, use back of form)</p>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Date of most recent tetanus immunization \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**MEDICATIONS:** Please print medication name, amount, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day

Signature of parent / caregiver / adult athlete: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## 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 hyper-extension, radial 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	<input type="checkbox"/> <input type="checkbox"/>	Has an x-ray evaluation for atlanto-axial instability been done?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_

<table border="0"> <tr><td>Normal</td><td>Abnormal</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Vision</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Hearing</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Oral cavity</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Neck</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Extremities</p>	Normal	Abnormal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr><td>Normal</td><td>Abnormal</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Extremities</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Cardiovascular system</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Respiratory system</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Gastrointestinal system</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Genitourinary system</p>	Normal	Abnormal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr><td>Normal</td><td>Abnormal</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Skin</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Cranial nerves</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Coordination</p> <table border="0"> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Reflexes</p>	Normal	Abnormal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other: \_\_\_\_\_

Primary MR Etiology / Category (if known): \_\_\_\_\_

I have received 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 NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EXAMINER'S SIGNATURE:

X \_\_\_\_\_

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

Phone: \_\_\_\_\_

**OFFICIAL SPECIAL OLYMPICS RELEASE FORM (To be completed by Adult Athlete)**

I, \_\_\_\_\_ am at least 18 years old and have submitted this application for participation in Special Olympics. I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed examiner has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from Special Olympics Chapter program in my state, or I have had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

Special Olympics has my permission, (both during and anytime after), to use my likeness, name, voice, or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature of Adult Athlete  \_\_\_\_\_ Date \_\_\_\_\_

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this release and has agreed to its terms.

Name (Print) \_\_\_\_\_ Relationship to athlete (e.g., family member, teacher, coach, etc.) \_\_\_\_\_

**OFFICIAL SPECIAL OLYMPICS RELEASE FORM (To be completed by Parent or Guardian of Minor Athlete)**

I am the parent / guardian of \_\_\_\_\_, the minor athlete, on whose behalf I have submitted this application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities. I further represent and warrant that to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed examiner has reviewed the health information set forth in the athlete's application, and has certified based on an independent medical examination that there is no medical evidence which would preclude the athlete's participation. I understand that if the athlete has Down Syndrome, he/she cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from Special Olympics Chapter program in my state, or the athlete has had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after), to Special Olympics to use the athlete's likeness, name, voice, or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

I am the parent (guardian) of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

I hereby give my permission for the athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent / Guardian  \_\_\_\_\_ Date \_\_\_\_\_