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APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS DISTRICT OF COLUMBIA

Directions for Completing the Form:

Please provide accurate information for all items. Incomplete forms will be returned. The forms must include: Signature of Release by Parent/Guardian or Adult Athlete, Signature of person completing the Health History and the Signature of the Physician completing the Physical examination

PLEASE PRINT **PROGRAM INFORMATION: TO BE COMPLETED BY PROGRAM COORDINATOR OR COACH**

Program/School/Agency Name _____ ☐ Not applicable (Independent athlete not affiliated with Program/School)

Address (on file ☐)_____ Phone # _____

_____ Fax # _____

Coach's Name_____ E-mail Address _____@_____

ATHLETE/CONTACT INFORMATION

☐ Male
☐ Female

Date of Birth (month/day/year) _____/_____/_____

Athlete's Social Security # _____-_____-_____

Athlete' s Name _____

Athlete Home Phone _____

Address _____

Health/Accident Insurance Company_____

Policy Number_____

_____

Contact Information

Parent/Guardian Name _____

Phone # _____

Address (if different from athlete) _____

Cell # _____

Pager #_____

_____

Emergency Contact (if other than Parent/Guardian)

_____

Relationship to Athlete _____ Phone #_____

SIGN ATHLETE HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER/ADULT ATHLETE

YES	NO	
☐	☐	* Heart Disease/ Heart defect/ High Blood pressure
☐	☐	* Chest Pain
☐	☐	* Seizures/ Epilepsy/ Fainting Spells
☐	☐	* Diabetes
☐	☐	* Asthma
☐	☐	* Concussion or serious head injury
☐	☐	* Major Surgery or Infectious Disease
☐	☐	Hepatitis/ Hepatitis B carrier
☐	☐	* Blindness/ Seriously impaired vision
☐	☐	Wears contact lenses/ glasses
☐	☐	Sickle cell trait or disease
☐	☐	Deafness/Substantial hearing loss/hearing aid

Date of most recent tetanus immunization _____/_____/_____

(*) Requires physical examination

YES	NO	
☐	☐	Allergy:
☐	☐	Medication _____
☐	☐	Food:_____
☐	☐	Insect stings/bites:_____
☐	☐	Bone or joint problems
☐	☐	requires wheelchair
☐	☐	uses walker / cane
☐	☐	Requires Special Diet (specify)_____
☐	☐	Emotional/psychiatric/ behavioral problems
☐	☐	requires close supervision
☐	☐	Tobacco use
☐	☐	Easy bleeding
☐	☐	Immunizations up to date
☐	☐	Other _____

MEDICATIONS:

	dosage (MM)	Times/day	prescription date

Please sign below to indicate that all of the above information is correct, accurate and up to date.

Signature of Parent/Guardian/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 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 team football competition (soccer).

YES NO **YES NO**

☐ ☐ Down's Syndrome 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)

SIGN PHYSICAL EXAMINATION: TO BE COMPLETED BY LICENSED PROFFESSIONAL

Blood Pressure: _____/_____ Weight: _____ Height: _____

Normal/Abnormal	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal
☐ ☐ Vision	☐ ☐ Cardiovascular system	☐ ☐ Respiratory system	☐ ☐ Reflexes	☐ ☐ Extremities
☐ ☐ Hearing	☐ ☐ Gastrointestinal system	☐ ☐ Cranial nerves	☐ ☐ Neck	Other _____
☐ ☐ Oral cavity	☐ ☐ Genitourinary system	☐ ☐ Coordination	☐ ☐ Skin	_____

Primary MR Etiology/Category (if known)_____

I am a licensed medical professional and have reviewed the above health information and performed the above examination on this athlete within the past 6 months and certify that this athlete can participate in Special Olympics (CHECK ONE) ☐without restrictions .

Examiner's Last Name (print)_____ ☐with the following restrictions.

RESTRICTIONS

_____

_____

Address _____ phone # :_____

SIGNATURE _____**DATE** _____/_____/_____

SIGN OFFICIAL SPECIAL OLYMPIC RELEASE SIGNATURE : TO BE COMPLETED BY PARENT/GUARDIAN/ADULT ATHLETE

I the undersigned, as the Parent/Guardian/or Adult Athlete have read and fully understand the provisions of the release form found on this page.

Signature of Parent/Guardian/Adult athlete_____ Date _____/_____/_____

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

I have submitted the attached 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 physician 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 the 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, squat lift, 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 and words in 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 an/or applying for funds to support those 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 either the parent (guardian) or adult Special Olympic 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/or Adult Athlete **Date**