APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS revised 1/18/08

BASIC INFORMATION

PROGRAM: _____

Athlete's Social Security # _____ - _____ - _____ (if US Citizen) ☐ Male ☐ Female Date of Birth (month/day/year) _____/_____/_____

Athlete's Name _____

Athlete's Address _____ Home Phone # _____

_____

Parent/Guardian's Name _____ Work Phone # _____

Parent/Guardian's Address (if different than athlete) _____ Home Phone # _____

_____

Emergency Contact (if other than parent/guardian) _____ Home Phone # _____

Health/Accident Insurance Company _____ Policy # _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No	
☐	☐	*Heart disease / heart defect / high blood pressure	☐	☐	Allergy:
☐	☐	*Chest pain	☐	☐	Medicines: _____
☐	☐	*Seizures / epilepsy/ fainting spells	☐	☐	Food: _____
☐	☐	*Diabetes	☐	☐	Insect stings/bites: _____
☐	☐	*Concussion or serious head injury	☐	☐	Special diet
☐	☐	*Major surgery or serious illness	☐	☐	*Asthma
☐	☐	Heat stroke / exhaustion	☐	☐	Tobacco use
☐	☐	Visually impaired/contact lenses/glasses	☐	☐	Easy bleeding
☐	☐	*Blind	☐	☐	Emotional / psychiatric / behavioral
☐	☐	Hearing impaired	☐	☐	Sickle cell trait or disease
☐	☐	Deaf/Complete hearing loss	☐	☐	Immunizations up to date
☐	☐	Bone or joint problem			

Date of most recent tetanus immunization _____/_____/_____ ☐ ☐ Other (for additional space, use back of form): _____

(*) Requires physical examination

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 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		
☐	☐	Vision	☐	☐	Cardiovascular system	☐	☐	Cranial nerves
☐	☐	Hearing	☐	☐	Respiratory system	☐	☐	Coordination
☐	☐	Oral cavity	☐	☐	Gastrointestinal system	☐	☐	Reflexes
☐	☐	Neck	☐	☐	Genitourinary system			
☐	☐	Extremities	☐	☐	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.

_____ **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 not participate in Special Olympics.**

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ Date _____/_____/_____

EXAMINER'S NAME: _____

ADDRESS: _____

_____ PHONE: _____

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

Special Olympics Montana

Special Olympics Montana

RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____ am at least 18 years old and have submitted the attached 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 physician 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 the 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 judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and football team competition (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 understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program that provides individual screening assessments of the health status and health care needs in the areas of: vision; oral health; hearing; podiatry; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that participation in the Healthy Athletes Program is voluntary and that I may decide not to participate. I understand that provision of these health services is not intended as a substitute for regular health care and that I should seek my own independent medical advice and assistance irrespective of the provision of these services. Neither Special Olympics, Inc. nor Special Olympics Montana through the provision of these services are responsible for my health or my health care.

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: _____

Relationship to athlete: _____

(e.g. family member, teacher, coach, etc.)

RELEASE 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 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 judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and football team competition (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 and/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.

By signing below, I am also permitting the Athlete to participate in the Special Olympics Healthy Athletes Program that provides individual screening assessments of the health status and health care needs in the areas of: vision; oral health; hearing; podiatry; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that participation in the healthy Athletes Program is voluntary and that I may decide that the Athlete will not participate. I understand that provision of these health services is not intended as a substitute for regular health care and that the Athlete should seek his/her own medical advice and assistance irrespective of the provision of these services. Neither Special Olympics Inc. nor Special Olympics Montana, through the provision of these services are responsible for the Athlete's health or health care.

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