Circle One

NEW RENEWAL

APPLICATION FOR PARTICIPATION (Medical Form)

(must be completed and signed by licensed examiner every 3 years)

REQUIRED

COUNTY ______________________ School/Agency:______________________

T-shirt Size: Children:__________ OR Adult:______________

LAST NAME______________________ FIRST______________________ SEX/DATE OF BIRTH **(REQUIRED)**

M or F ______ month/day/year ____/____/____

Street Number/Address______________________

City______________________ State ________ Zip Code______________ Email ______________________

Parent/Guardian______________________ Cell Phone (______)______________

Address (if different)______________________ Home Phone (______)______________

City______________________ State__________ Zip Code______________ P/G Email ______________________

Emergency Contact (other than parent/guardian)______________________ Emerg. Phone (______)______________

Health Insurance Company______________________ Ins. Policy #______________________

REQUIRED → Signature of parent/legal guardian/adult athlete completing form______________________

REQUIRED → **ALSO PRINT NAME** ______________________

FOR ATHLETES WITH DOWN SYNDROME – Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

☐ Yes ☐ No Has an x-ray evaluation for atlantoaxial instability been done?

☐ Yes ☐ No If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

IS THERE PRESENT OR A HISTORY OF (to be completed by parent/caregiver):

Blind	☐ Yes	Tobacco use	☐ Yes	Emotional/psychiatric/behavioral problems	☐ Yes
Deaf	☐ Yes	Major surgery or serious illness	☐ Yes	Asthma/breathing problems with exertion	☐ Yes
Heart problems/high blood pressure	☐ Yes	Heat stroke/exhaustion	☐ Yes	Contact lenses/glasses/dentures/false teeth	☐ Yes
Seizures/epilepsy/fainting spells	☐ Yes	Easy bleeding	☐ Yes	Head injury/history of concussion	☐ Yes
Diabetes	☐ Yes	Bone/joint problems	☐ Yes	Immunizations (shots) are up-to-date	☐ Yes
Hearing aid/hearing problems	☐ Yes	Sickle cell disease or trait	☐ Yes	Special Diet Needs (list below)	☐ Yes
Blindness/vision problem	☐ Yes	Uses a wheelchair	☐ Yes	Year of last tetanus shot______________	

Other problems that would interfere with participation ______________________

Allergy to the following (list specific):

Food______________________ Insect sting/bites______________________

Medication______________________

MEDICATIONS

Medication Name	Dosage	Date Presc.	Times per day	Medication Name	Dosage	Date Presc.	Times per day

PHYSICAL EXAMINATION

			Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Blood Pressure	_____	Vision	☐	☐	Oral Cavity	☐	☐	Cardiovascular system	☐	☐
Pulse	_____	Hearing	☐	☐	Extremities	☐	☐	Respiratory system	☐	☐
Weight	_____	Neck	☐	☐	Coordination	☐	☐	Gastrointestinal system	☐	☐
Height	_____	Skin	☐	☐	Reflexes	☐	☐	Genitourinary system	☐	☐
								Cranial nerves	☐	☐

Other:______________________

Primary MR Etiology/Category______________________

I have reviewed the above health information and examined the athlete named in the application and certify that there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions______________________

REQUIRED Examiner's Name:______________________ Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP

REQUIRED EXAMINER'S SIGNATURE______________________ **REQUIRED DATE:**______________

OPTIONAL INFORMATION

Ethnic background: ☐○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Other______________

OFFICIAL SPECIAL OLYMPICS ATHLETE RELEASE FORM

COUNTY: ________________________________ **SCHOOL/AGENCY:**____________________________________

ATHLETE NAME Last:_________________________________ First:____

DATE OF BIRTH: _______/________/________
month day year

I represent and warrant that, to the best of my knowledge and belief, I (or my minor child) am (is) physically and mentally able to participate in Special Olympics activities. I represent that I meet the eligibility requirement(s) for participation in Special Olympics by having an intellectual and/or developmental disability. I also represent that a licensed physician has reviewed the health information contained in my (or my minor child's) application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me (or my minor child) from participating in Special Olympics. I understand that if I (or my minor child) have (has) Down Syndrome, I (or my minor child) cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my (or my minor child's) 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 Program in my area, or I (or my minor child) have (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, I (or my minor child) must have the radiological examination before I (or my minor child) can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football (soccer).

Special Olympics has my permission, (both during and anytime after), to use my (or my minor child'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 soliciting funds, directly or in conjunction with an approved third party, to support these purposes and activities.

Special Olympics Florida shall not deny an applicant or revoke a volunteer's status for reasons of ethnicity, gender, sexual orientation or age.

TO BE COMPLETED BY
ADULT ATHLETE AND ONE WITNESS

If, during my participation in Special Olympics activities, I should need emergency 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 it is my responsibility to acquire, review and complete the Athlete Code of Conduct form for the safety and health of both myself and my fellow athletes.

I am at least 18 years old and have submitted the attached application for participation in Special Olympics. I 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.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact my local Program office if I have any questions about housing arrangements for a specific event or the housing policy in general.

______________________________________ ____________________

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.

______________________________________ ______________________________ ______________

SIGNATURE OF WITNESS **PRINT NAME OF WITNESS** **RELATIONSHIP**

OR

TO BE COMPLETED BY
PARENT/LEGAL GUARDIAN OF MINOR ATHLETE

If a medical emergency should arise during the minor 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 minor athlete's health and well-being.

I understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form, with and for my athlete, for the safety and health of both my child/guard and their fellow athletes.

I am the parent/guardian of the minor 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 permission for the athlete named above to participate in Special Olympics games, recreation programs and physical activity programs.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact my local Program office if I have any questions about housing arrangements for a specific event or the housing policy in general.

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____ ______________

SIGNATURE OF PARENT/ LEGAL GUARDIAN **DATE**

PRINT NAME _______________________________