

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

DEMOGRAPHICS

PROGRAM: _____

Athlete's Social Security # _____ (if US Citizen) Male E3 Female Date of Birth (month/day/year) ____/____/____

Athlete's Name _____

Athlete's Address _____ Athlete Home Phone # _____

City _____ State _____ Zip _____

Parent/Guardian's Name _____ Parent Primary Phone # _____

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

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

Health/Accident Insurance Company _____ Policy # _____

HEALTH HISTORY - TO BE COMPLETED BY PARENT/CAREGIVER

<table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>CD *Heart disease / heart defect / high blood pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Chest pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>I I *Seizures / epilepsy/fainting spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Concussion or serious head injury</td></tr> <tr><td>EH</td><td>CD</td><td>*Major surgery or serious illness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heat stroke / exhaustion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Blindness / visual problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Contact lenses / glasses</td></tr> <tr><td><input type="checkbox"/></td><td>I I</td><td>Hearing loss / hearing aid</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or joint problem</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	CD *Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	*Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	I I *Seizures / epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	*Concussion or serious head injury	EH	CD	*Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	*Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	I I	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>D CD Allergy: _____</td></tr> <tr><td>CD</td><td>CD</td><td>Medicines: _____</td></tr> <tr><td>CD</td><td><input type="checkbox"/></td><td>Food: _____</td></tr> <tr><td></td><td></td><td>s/bites: _____</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	D CD Allergy: _____	CD	CD	Medicines: _____	CD	<input type="checkbox"/>	Food: _____			s/bites: _____
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Reasons that medicals are sent back

1. No Social Security Number
2. No Parent Signature
3. If you play soccer and have Downs Syndrome- You will need The Atlanto-Axial X-ray
4. Must be signed by a Dr. , a CNP will not work
5. No address for the Dr.

Date of most recent tetanus immunization _____

(* Requires physical examination)

Medications:

Please print medication name, amount, date

Medication Name	Dosage	Date Prescribed	Times per day

Signature of parent/caregiver/adult athlete: _____ date ____/____/____

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).

EH EH Has an x-ray evaluation for atlanto-axial instability been done?

FI EH 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 CD <input type="checkbox"/> Vision D <input type="checkbox"/> Hearing CD <input type="checkbox"/> Oral cavity CD <input type="checkbox"/> Neck CD <input type="checkbox"/> Extremities	Normal/Abnormal EH EH Cardiovascular system EH EH Respiratory system EH EH Gastrointestinal system CD EH Genitourinary system CD CD Skin	Normal/Abnormal EH EH Cranial nerves EH EH Coordination CD CD Reflexes
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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.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ Date: _____

EXAMINER'S NAME: _____

ADDRESS: _____ PHONE: _____

Must be a Dr. - NOT a NURSE