APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

[ ] Check If **NEW** Athlete (Never participated in Special Olympics before)

Please return to:

ELIGIBILITY FOR PARTICIPATION IN SPECIAL OLYMPICS: Every person with Intellectual Disabilities is eligible to participate in Special Olympics. A person is considered to have Intellectual Disabilities if that person satisfies any one of the following requirements: 1) person has been identified by an agency or professional as having Intellectual Disabilities, 2) person has a cognitive delay, as determined by standardized measures such as intelligence quotient or "IQ" testing or other measures which are generally accepted as being a reliable measurement of the existence of a cognitive delay, or 3) person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as IQ) and in adaptive skills (such as in recreation, work, independent living, or self-care). Persons whose functional limitations are based solely on a physical, behavioral, emotional disability, or a specific learning or sensory disability are not eligible to participate in Special Olympics.

SECTION A – ATHLETE INFORMATION *Required once every three (3) years for all athletes.*

Please print clearly in blue or black ink.

REGION/AREA/LOCAL PROGRAM: ____ YEAR STARTED IN SPECIAL OLYMPICS: ____________

ATHLETE INFORMATION

ATHLETE NAME: (LAST)_____________________________ (FIRST)_____________________________ (NICKNAME)________________________

DATE OF BIRTH (month/day/year): _______ / _______ / _______

SOCIAL SECURITY NUMBER: _______ - _______ - _______

GENDER (circle): Male Female

EMAIL: ____

ADDRESS: ____(APT/STE)______

HOME PHONE: (_______) ________________________

CITY: ____ STATE: _______ ZIP: ________

MOBILE PHONE: (_______)________________________

HEALTH INSURANCE COMPANY: ____

POLICY #: ____

ETHNIC BACKGROUND: African Amer.→ [ ] Anglo→ [ ] Asian/Pacific Islands→ [ ] Hispanic→ [ ] Native Amer.→ [ ] Other not listed→ [ ] ________________

ATHLETE EMPLOYMENT INFORMATION

EMPLOYER: ____

WORK PHONE: (_______)________________________

ADDRESS: ____

CITY: ____ STATE: _______ ZIP: ________

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN NAME: ____

HOME PHONE: (_______) ______________________

ADDRESS: ____

MOBILE PHONE: (_______) ______________________

CITY: ____ STATE: ______ ZIP: ________

WORK PHONE: (_______) ______________________

EMAIL: ____

PARENT/GUARDIAN EMPLOYMENT INFORMATION

EMPLOYER: ____

EMPLOYER PHONE: (_______)_____________________

ADDRESS: ____

CITY: ____ STATE: _______ Zip: ________

EMERGENCY CONTACT INFORMATION

CONTACT: ____

RELATIONSHIP: ____________________________________

HOME PHONE: (_______) ______________________

MOBILE PHONE: (_______) ______________________

FOR OFFICE USE ONLY

Date Received: ____ Verified by: ____

ATHLETE NAME: (LAST)_____________________________ (FIRST)_____________________________

SECTION B – ATHLETE HEALTH INFORMATION *Required once every three (3) years for all athletes.*

Please print clearly in blue or black ink.

MEDICAL HISTORY

IMPORTANT: Any significant change in the athlete's health or condition should be reviewed by a licensed examiner before further participation.

		Yes	No	New Problem
1.	Heart Disease/Heart Defect/High Blood Pressure	☐	☐	
2.	Chest Pain or Fainting Spells	☐	☐	
3.	Seizures/Epilepsy	☐	☐	
4.	Diabetes	☐	☐	
5.	Down Syndrome	☐	☐	
	Have cervical spine (neck bone) x-rays been done	☐	☐	
	Atlanto Axial Instability	☐	☐	
6.	Parent/Sibling (under 40) died of heart disease	☐	☐	☐
7.	Absence of one kidney or testicle	☐	☐	☐
8.	Concussion or serious head injury	☐	☐	☐
9.	Major surgery or serious illness	☐	☐	☐
10.	Heat stroke/exhaustion	☐	☐	☐
11.	Other problem that would interfere w/ sports participation	☐	☐	
	List ____			
12.	Impaired motor ability	☐	☐	
13.	Uses a wheelchair	☐	☐	

		Yes	No
14.	Allergy to the following (be specific)	☐	☐
	Medicine ______________________________	☐	☐
	Foods ______________________________	☐	☐
	Insect Sting/Bite ______________________	☐	☐
15.	Special Diet __________________________	☐	☐
16.	Exercise induced wheezing	☐	☐
17.	Tendency to bleed easily	☐	☐
18.	Emotional/psychiatric/behavioral problems	☐	☐
19.	Serious bone or joint disorder	☐	☐
20.	Sickle cell trait or disease	☐	☐
21.	Hearing aid/hearing loss	☐	☐
22.	Contact lenses/eyeglasses	☐	☐
23.	Dentures/false teeth	☐	☐
24.	Immunizations (shots) are up-to-date	☐	☐
25.	Date of last tetanus shot	______ / ______ / ______	

ADDITIONAL COMMENTS

____

____

____

MEDICATIONS Please print medication name, amount, date prescribed and number of times per day medication needs to be taken

____

____

____

____

PERSON COMPLETING FORM (normally parent/guardian or adult athlete) ____ ___________

Signature Date

IF HISTORY SIGNED BY ADULT ATHLETE – I have reviewed the health history with the athlete whose signature appears above

_________________________________ ____________ _________________________________

Signature Date Relationship to athlete (family member, friends, coach)

SECTION C - MEDICAL CERTIFICATION *Required once every three (3) years for all athletes.*

MUST BE PERFORMED AND COMPLETED BY A LICENSED MEDICAL EXAMINER (PHYSICIAN, PHYSICIAN ASSISTANT, OR CHIROPRACTOR)

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: gymnastics, pentathlon, butterfly stroke in aquatics, diving start in aquatics, high jump, & soccer (football).

BRIEF EXAM: HT ___________ WT: ___________ PULSE: ___________ B.P. ___________ ENT: ___________ HEART: ___________ LUNGS: ___________

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

RESTRICTIONS ____

Examiner's Signature ____ Date: ____________________

Examiner's Name ____ Phone (______) ____________________

Address ____________________________________ City ________________________ Zip ____________