MEDICAL RELEASE FOR ATHLETES WITH DOWN SYNDROME PARTICIPATING IN RESTRICTED SPORTS AS PART OF SPECIAL OLYMPICS SOUTHERN CALIFORNIA

Special Olympics Southern California

This form must be completed and signed by the examining Physician for each individual with Down Syndrome who is expected to participate in one of the following sports activities:

Diving start in AQ	High Jump	Soccer (Football)
Butterfly Stroke in AQ	Pentathlon	Gymnastics

Athlete's Name_____ **SS #** _____-_____-_____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Restrictions: _____

Note To Examining Physician: Medical studies have demonstrated that approximately 10% of Down Syndrome individuals have a condition of the upper spine called Atlanto-Axial Instability. Special Olympics, Inc. requires that any athlete with Down Syndrome competing in the above listed sports be examined for the condition. The examination must include x-ray of full extension and flexion of the neck.

Physician Statement:
On examination of cervical spine x-rays including full flexion and full extension views, I find that the above named athlete has:

(Check One) _____ No evidence of Atlanto-Axial
_____ Positive or equivocal of Atlanto-Axial Instability

_____	_____	_____
Date	Phone	Name of Physician
_____		_____
Address/City/Zip		Signature of Physician

Parent Statement (to be completed by Parent or Guardian of minor Athlete)
This is to affirm that I have been informed about the condition called Atlanto-Axial Instability. I understand that in order for a Special Olympics Athlete with Down Syndrome to begin or continue in one or more of the below listed sports, he/she must be examined and cleared for this condition.

____ Diving start in AQ	____ High Jump	____ Soccer (Football)
____ Butterfly stroke in AQ	____ Pentathlon	____ Gymnastics

As the Parent(s) and/or legal guardian of _____, I /we give permission for his/her unrestricted participation in Special Olympics activities.

Signed _____ _____
Athlete's Parent or Guardian — Date