# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS OREGON
# ATHLETE MEDICAL

- PLEASE PRINT CLEARLY using a blue or black pen -



## BASIC INFORMATION

LOCAL PROGRAM ____________ ☐ MALE ☐ FEMALE

ATHLETE'S LEGAL NAME ____________ Date of Birth (MM/DD/YY) ____/____/____

ATHLETE'S ADDRESS ____________ PHONE ____________

CITY STATE ZIP ____________ E-MAIL ____________

PARENT/GUARDIAN'S NAME ____________

PARENT/GUARDIAN'S ADDRESS ____________ PHONE ____________

EMERGENCY CONTACT ____________ PHONE ____________

HEALTH/ACCIDENT INSURANCE COMPANY ____________ POLICY # ____________

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/LEGAL GUARDIAN/CAREGIVER/ADULT ATHLETE

| YES | NO | |
|---|---|---|
| ☐ | ☐ | USES A WHEEL CHAIR |
| ☐ | ☐ | HEART DISEASE / HEART DEFECT / HIGH BLOOD PRESSURE (CIRCLE) |
| ☐ | ☐ | CHEST PAIN ____________ |
| ☐ | ☐ | SEIZURES / EPILEPSY/ FAINTING SPELLS (CIRCLE) |
| ☐ | ☐ | DIABETES |
| ☐ | ☐ | CONCUSSION OR SERIOUS HEAD INJURY ____________ |
| ☐ | ☐ | MAJOR SURGERY OR SERIOUS ILLNESS |
| ☐ | ☐ | HEAT STROKE / EXHAUSTION ____________ |
| ☐ | ☐ | BLINDNESS / VISUAL PROBLEM ____________ |
| ☐ | ☐ | CONTACT LENSES / GLASSES ____________ |
| ☐ | ☐ | HEARING LOSS / HEARING AID |
| ☐ | ☐ | BONE OR JOINT PROBLEM |

ALLERGIES?

MISC: ____________

MEDICATIONS: ____________

FOOD: ____________

INSECT STINGS/BITES ____________

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | SPECIAL DIET | ☐ | ☐ | TOBACCO USE |
| ☐ | ☐ | ASTHMA | ☐ | ☐ | EASY BLEEDING |
| ☐ | ☐ | EMOTIONAL / PSYCHIATRIC / BEHAVIORAL ____________ | | | |
| ☐ | ☐ | SICKLE CELL TRAIT OR DISEASE | | | |
| ☐ | ☐ | IMMUNIZATIONS UP TO DATE | | | |
| | | DATE OF LAST TETANUS IMMUNIZATION: ____/____/____ | | | |
| ☐ | ☐ | DOWN SYNDROME (SEE AAI ASSESSMENT BELOW) | | | |

**Medications: Does athlete regularly take medications?** YES ☐ NO ☐ Please supply a list of all medications, dosage & when taken

| MEDICATION NAME | DOSAGE | TIMES PER DAY | MEDICATION NAME | DOSAGE | TIMES PER DAY |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

## FOR ATHLETES WITH DOWN SYNDROME: ATLANTO-AXIAL INSTABILITY (AAI) ASSESSMENT

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, radial flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: 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? Date of X-ray: ____/____/____ |

## PHYSICAL EXAMINATION

Blood pressure: ____/____ Weight: ________ Height: ________ Temperature: ________ Pulse: ________

| 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: ____________

**PLEASE CIRCLE ANY RESTRICTED SPORTS FOR THIS ATHLETE: ALPINE SKI, AQUATICS, DIVING STARTS IN AQUATICS, ATHLETICS (TRACK & FIELD), BASKETBALL, BOCCE, BOWLING, CROSS-COUNTRY SKI, GOLF, GYMNASTICS, LONG-DISTANCE RUNNING, POWER LIFTING, SNOWBOARD, SNOWSHOE, SOCCER, SOFTBALL, VOLLEYBALL – OTHER (PLEASE LIST):**

**I HAVE REVIEWED THE ABOVE HEALTH INFORMATION AND EXAMINED THE ATHLETE NAMED IN THIS APPLICATION AND CERTIFY THAT THERE IS NO MEDICAL EVIDENCE AVAILABLE WHICH WOULD PRECLUDE THIS ATHLETE FROM PARTICIPATING IN SPECIAL OLYMPICS.**

RESTRICTIONS: ____________

EXAMINER'S SIGNATURE: ____________ DATE ____/____/____

EXAMINER'S NAME: ____________ PHONE (WITH AREA CODE): ____________

ADDRESS: ____________



**OFFICE USE ONLY**
EXP DATE ____/____/____

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS OREGON ATHLETE MEDICAL

**IMPORTANT: This application must be renewed every 3 years OR if there is any significant change in the athlete's health.**

## OFFICIAL SPECIAL OLYMPICS RELEASE FORM

PLEASE CHECK THE BOX WHICH APPLIES TO YOU OR THE APPLICANT (check one box only):

- ☐ I am at least 18 years old and my own legal guardian (can legally sign release form for myself)
- ☐ I am at least 18 years old and **NOT** my own legal guardian (legal guardian must sign this release form)
- ☐ I am the parent/guardian of a MINOR athlete (parent or legal guardian must sign this release form)

I represent and warrant that, to the best of my knowledge and belief, _______________________________________ is physically and mentally able to participate in Special Olympics activities. With my approval, a licensed physician has reviewed the health in this 'Application for Participation' and has certified, based on an independent medical examination, that there is no medical evidence which would preclude the athlete's participation in Special Olympics. 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 a full radiological examination which establishes the absence of Atlanto-Axial Instability. I understand that I must have the radiological examination before I can participate in gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer).

In permitting the athlete, (both during and anytime after participation), I am specifically granting my permission to Special Olympics to use athlete's likeness, name, voice, or words in any 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 a medical emergency should arise during the athlete's participation in any Special Olympics activities at any time, and athlete is not able to give consent or parent/legal guardian is not personally present to be consulted, I authorize Special Olympics to take whatever measures are necessary to protect the athlete's health and well-being, including, if necessary, hospitalization.

I acknowledge that Special Olympics events may occasionally involve overnight activities and that the housing arrangements made by Special Olympics staff or appointed volunteers may differ for each event. I understand that I may contact Special Olympics Oregon if I have any questions about housing arrangements for a specific event or the housing policy in general.

By signing, I also authorize the participation of this athlete in the Healthy Athletes Programs which offer non-invasive health care services to athletes at Special Olympics events. Services may be offered in the following areas: vision; oral health care; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand the following: 1) participation in the Healthy Athletes venues is free of charge; 2) participation is voluntary and that authorization can be withdrawn at any time without penalty (with written 30 day notice to state office); 3) participation in Healthy Athletes is not a requirement for participation in other Special Olympics activities; 4) the provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future; and 5) information that is gathered as a part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

- **I, the athlete named above**, have read this consent form and fully understand (or have had someone to fully explain to me) the provisions of the release that I am signing. I understand that by signing, I am agreeing to all the provisions of this release. I hereby agree that I will be bound thereby and I shall defend you and hold you harmless for any disaffirmation thereof.

_______________________________________________ _______________________

**Signature of Adult Athlete (over 18 and own guardian)** **Date**

- **As parent or legal guardian of the athlete named above**, have read this consent form and fully understand the provisions of the above release form. I understand that by signing, I am agreeing to all the provisions of this release. I hereby agree that I and said person will be bound thereby and I shall defend you and hold you harmless for any disaffirmation thereof by said person.

_______________________________________________ _______________________

**Signature of parent or legal guardian** **Date**

## RETURN COMPLETED FORM TO:

DO NOT FAX – please return the original form to your local program.