APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

(Physical Examination with Examiner's signature required every 3 years)

LAST NAME, First Name______________ Form Expiration Date ___/___/___

BASIC INFORMATION

Delegation (Team) ________________________________ *Please print clearly. All information is* ***required***.

Name

Male ☐ Female ☐ Date of Birth __/__/____ Phone # ___-___-____

Street Address or PO Box Apt. #

City/Town State ZIP Code + 4

Emergency Contact Name Emergency Contact Phone #

Ethnicity (optional) ☐ White ☐ Hispanic/Latin ☐ Black/African American ☐ Native American ☐ Asian ☐ Other______________________

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No	
☐	☐	*Asthma
☐	☐	*Heart disease/heart defect
☐	☐	*High blood pressure
☐	☐	*Chest pain
☐	☐	*Seizures/epilepsy/fainting spells
☐	☐	*Diabetes
☐	☐	*Concussion or serious head injury
☐	☐	*Major surgery or serious illness
☐	☐	*Blindness/visual problem

Yes	No	
☐	☐	Heat stroke/exhaustion
☐	☐	Contact lenses/glasses
☐	☐	Hearing loss/hearing aid
☐	☐	Bone or joint problem
☐	☐	Emotional/psychiatric/behavioral
☐	☐	Sickle cell trait or disease
☐	☐	Immunizations up to date
☐	☐	Special diet
☐	☐	Tobacco use

Yes	No	
☐	☐	Easy bleeding
		Allergies:
☐	☐	Medicines:__________________________
☐	☐	Food:_______________________________
☐	☐	Insect stings/bites:___________________
☐	☐	Other Allergies_______________________
		______________________________________
		(*) Requires physical examination
☐	☐	**Down Syndrome****

**Must complete the Atlanto-Axial Instability Assessment questionaire below

Date of most recent tetanus immunization _____/_____/_____

MEDICATIONS:

Please print medication name, amount, date prescribed and number of times per day mediation is given.

Medication Name	Dosage	Date	Times	Medication Name	Dosage	Date	Times

Signature of parent/caregiver/adult athlete:_______________________________________ **Date** ____/____/____

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

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).

Yes	No	
☐	☐	Has an x-ray evaluation for Atlanto-Axial Instability been done? Date ___/___/___
☐	☐	If yes, was it positive for Atlanto-Axial Instability? (positive indicates that the atlanto-dens interval is 5mm or more)
☐	☐	If yes, you must complete the Special Release Form on the next page.

PHYSICAL EXAMINATION (to be completed by Health Professional)

Blood Pressure:_____/_____ Weight:______ Height:_____

Normal	Abnormal	
☐	☐	Vision
☐	☐	Hearing
☐	☐	Oral Cavity
☐	☐	Neck
☐	☐	Extremities

Normal	Abnormal	
☐	☐	Cardiovascular System
☐	☐	Respiratory System
☐	☐	Gastrointestinal System
☐	☐	Genitourinary System
☐	☐	Skin

Normal	Abnormal	
☐	☐	Cranial Nerves
☐	☐	Coordination
☐	☐	Reflexes

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 (NO DOCTOR'S SIGNATURE STAMPS PLEASE)

RESTRICTIONS:_________________________________ EXAMINER'S NAME:___________________________

EXAMINER'S SIGNATURE:__________________________ DATE: _____ / _____ / _____

ADDRESS:______________________________________ PHONE:____________________________________