



APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS OREGON ATHLETE MEDICAL

Office Use only
SC : _____

- PLEASE PRINT CLEARLY using a blue or black pen -

BASIC INFORMATION

SCHOOL _____ 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

<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> USES A WHEEL CHAIR</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART DISEASE / HEART DEFECT / HIGH BLOOD PRESSURE (CIRCLE)</p> <p><input type="checkbox"/> <input type="checkbox"/> CHEST PAIN _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SEIZURES / EPILEPSY/ FAINTING SPELLS (CIRCLE)</p> <p><input type="checkbox"/> <input type="checkbox"/> DIABETES</p> <p><input type="checkbox"/> <input type="checkbox"/> CONCUSSION OR SERIOUS HEAD INJURY _____</p> <p><input type="checkbox"/> <input type="checkbox"/> MAJOR SURGERY OR SERIOUS ILLNESS _____</p> <p><input type="checkbox"/> <input type="checkbox"/> HEAT STROKE / EXHAUSTION _____</p> <p><input type="checkbox"/> <input type="checkbox"/> BLINDNESS / VISUAL PROBLEM _____</p> <p><input type="checkbox"/> <input type="checkbox"/> CONTACT LENSES / GLASSES _____</p> <p><input type="checkbox"/> <input type="checkbox"/> HEARING LOSS / HEARING AID _____</p> <p><input type="checkbox"/> <input type="checkbox"/> BONE OR JOINT PROBLEM _____</p>	<p>ALLERGIES?</p> <p>MISC: _____</p> <p>MEDICATIONS: _____</p> <p>FOOD: _____</p> <p>INSECT STINGS/BITES _____</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">YES</td> <td style="width: 25%;">NO</td> <td style="width: 25%;">YES</td> <td style="width: 25%;">NO</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">SPECIAL DIET</td> <td colspan="2">TOBACCO USE</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">ASTHMA</td> <td colspan="2">EASY BLEEDING</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2">EMOTIONAL / PSYCHIATRIC / BEHAVIORAL _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2">SICKLE CELL TRAIT OR DISEASE _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2">IMMUNIZATIONS UP TO DATE _____</td> </tr> <tr> <td colspan="4">DATE OF LAST TETANUS IMMUNIZATION: ____/____/____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="2">DOWN SYNDROME (SEE AAI ASSESSMENT BELOW)</td> </tr> </table>	YES	NO	YES	NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SPECIAL DIET		TOBACCO USE		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA		EASY BLEEDING		<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL / PSYCHIATRIC / BEHAVIORAL _____		<input type="checkbox"/>	<input type="checkbox"/>	SICKLE CELL TRAIT OR DISEASE _____		<input type="checkbox"/>	<input type="checkbox"/>	IMMUNIZATIONS UP TO DATE _____		DATE OF LAST TETANUS IMMUNIZATION: ____/____/____				<input type="checkbox"/>	<input type="checkbox"/>	DOWN SYNDROME (SEE AAI ASSESSMENT BELOW)	
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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: _____

<p>NORMAL ABNORMAL</p> <p><input type="checkbox"/> <input type="checkbox"/> VISION</p> <p><input type="checkbox"/> <input type="checkbox"/> HEARING</p> <p><input type="checkbox"/> <input type="checkbox"/> ORAL CAVITY</p> <p><input type="checkbox"/> <input type="checkbox"/> NECK</p> <p><input type="checkbox"/> <input type="checkbox"/> EXTREMITIES</p>	<p>NORMAL ABNORMAL</p> <p><input type="checkbox"/> <input type="checkbox"/> CARDIOVASCULAR SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> RESPIRATORY SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> GASTROINTESTINAL SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> GENITOURINARY SYSTEM</p> <p><input type="checkbox"/> <input type="checkbox"/> SKIN</p>	<p>NORMAL ABNORMAL</p> <p><input type="checkbox"/> <input type="checkbox"/> CRANIAL NERVES</p> <p><input type="checkbox"/> <input type="checkbox"/> COORDINATION</p> <p><input type="checkbox"/> <input type="checkbox"/> REFLEXES</p>
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Other: _____

Primary MR Etiology/Category: _____

PLEASE CIRCLE ANY RESTRICTED SPORTS FOR THIS ATHLETE: ALPINE SKI, AQUATICS, DIVING STARTS IN AQUATICS, ATHLETICS (TRACK & FIELD), BASKETBALL, BOCCIE, 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: _____

**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:

Special Olympics Oregon
Attn: Alix Wastaney
5901 SW Macadam Ave., St. 200
Portland, OR 97239