



APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

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

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 intelligent 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): _____ / _____ / _____

GENDER (circle): Male Female

ADDRESS: _____ (APT/STE) _____ HOME PHONE: (_____) _____

CITY: _____ STATE: _____ ZIP: _____ MOBILE PHONE: (_____) _____

EMAIL: _____

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: _____

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		Yes	No
1. Heart Disease/Heart Defect/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	14. Allergy to the following (be specific)	<input type="checkbox"/>	<input type="checkbox"/>
2. Chest Pain or Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Foods _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Insect Sting/Bite _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	15. Special Diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Have cervical spine (neck bone) x-rays been done	<input type="checkbox"/>	<input type="checkbox"/>	16. Exercise induced wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Atlanto Axial Instability	<input type="checkbox"/>	<input type="checkbox"/>	17. Tendency to bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
6. Parent/Sibling (under 40) died of heart disease	<input type="checkbox"/>	<input type="checkbox"/>	18. Emotional/psychiatric/behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Absence of one kidney or testicle	<input type="checkbox"/>	<input type="checkbox"/>	19. Serious bone or joint disorder	<input type="checkbox"/>	<input type="checkbox"/>
8. Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	20. Sickle cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>
9. Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	21. Hearing aid/hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
10. Heat stroke/exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	22. Contact lenses/eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>
11. Other problem that would interfere w/ sports participation	<input type="checkbox"/>	<input type="checkbox"/>	23. Dentures/false teeth	<input type="checkbox"/>	<input type="checkbox"/>
List _____			24. Immunizations (shots) are up-to-date	<input type="checkbox"/>	<input type="checkbox"/>
12. Impaired motor ability	<input type="checkbox"/>	<input type="checkbox"/>	25. Date of last tetanus shot _____ / _____ / _____		
13. Uses a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>			

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 _____