

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

PROGRAM \_\_\_\_\_

AREA \_\_\_\_\_

## DEMOGRAPHICS

Athlete's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (if US Citizen)  Male  Female Date of Birth (month/day/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Athlete's Name \_\_\_\_\_

Athlete's Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Athlete Home Phone # \_\_\_\_\_

Parent/Guardian's Address (if different than athlete) \_\_\_\_\_ Parent Primary Phone # \_\_\_\_\_  
 Parent Secondary Phone # \_\_\_\_\_

Emergency Contact (if other than parent/guardian) \_\_\_\_\_ Primary Phone # \_\_\_\_\_

Health/Accident Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

<table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Heart disease / heart defect / high blood pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Chest pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Seizures / epilepsy/fainting spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Concussion or serious head injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Major surgery or serious illness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heat stroke / exhaustion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Blindness / visual problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Contact lenses / glasses</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hearing loss / hearing aid</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or joint problem</td></tr> </table> <p>Date of most recent tetanus immunization _____/_____/_____</p> <p>(*) Requires physical examination</p>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	*Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	*Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	*Seizures / epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	*Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	*Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	*Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergy: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Medicines: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Food: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Insect stings/bites: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Special diet _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Asthma _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tobacco use _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Easy bleeding/History of Blood Disorders _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Emotional / psychiatric / behavioral _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sickle cell trait or disease _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Immunizations up to date _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other (for additional space, use back of form): _____</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Allergy: _____	<input type="checkbox"/>	<input type="checkbox"/>	Medicines: _____	<input type="checkbox"/>	<input type="checkbox"/>	Food: _____	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites: _____	<input type="checkbox"/>	<input type="checkbox"/>	Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>	*Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use _____	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding/History of Blood Disorders _____	<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 _____	<input type="checkbox"/>	<input type="checkbox"/>	Other (for additional space, use back of form): _____
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**Medications:**

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

Medication Name	Dosage	Date Prescribed.	Times per day	Medication Name	Dosage	Date Prescribed.	Times per day

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)

## PHYSICAL EXAMINATION

Blood pressure: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Normal/Abnormal <input type="checkbox"/> <input type="checkbox"/> Vision <input type="checkbox"/> <input type="checkbox"/> Hearing <input type="checkbox"/> <input type="checkbox"/> Oral cavity <input type="checkbox"/> <input type="checkbox"/> Neck <input type="checkbox"/> <input type="checkbox"/> Extremities	Normal/Abnormal <input type="checkbox"/> <input type="checkbox"/> Cardiovascular system <input type="checkbox"/> <input type="checkbox"/> Respiratory system <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal system <input type="checkbox"/> <input type="checkbox"/> Genitourinary system <input type="checkbox"/> <input type="checkbox"/> Skin	Normal/Abnormal <input type="checkbox"/> <input type="checkbox"/> Cranial nerves <input type="checkbox"/> <input type="checkbox"/> Coordination <input type="checkbox"/> <input type="checkbox"/> Reflexes
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Other: \_\_\_\_\_

Primary MR Etiology/Category (If known): \_\_\_\_\_

Abnormalities \_\_\_\_\_

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.

RESTRICTIONS: \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

EXAMINER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_