IMPORTANT: This form is not valid unless signed by Physician on page 1 and Adult Athlete or Guardian on page 2.
FORM IS VALID FOR THREE (3) YEARS FROM DATE OF PHYSICAL EXAM.

Special Olympics Washington

APPLICATION FOR PARTICIPATION

Team/Program Affiliation:_____

Western Washington – 1809 7th Ave, Suite 1509, Seattle, WA 98101-4400 Ph. 1.800.752.7559 or 206.362.4949 Fax 206.361.8158
Eastern Washington – PO Box 1640 Richland, WA 99352-6640 Ph. 1.800.442.2508 or 509.946.5921 Fax 509.396.9902

ATHLETE INFORMATION

Athlete Name: _____ Date of Birth: ___ /___ /___ Gender: ☐ Male ☐ Female
Address:_____ City: _____ State: _____ Zip Code: _____
Phone: ( )_____ Ethnicity: _____ E-mail: _____@_____
Employer: _____ Address: _____ Phone: ( )_____
Emergency Contact: _____ Phone:( )_____ Phone#2:( )_____ Relationship: _____
Health/Accident Insurance Company: _____ Policy Number: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Phone:( )_____ Phone#2:( )_____ E-mail: _____@_____
Address:_____ City: _____ State: _____ Zip Code: _____

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

YES	NO	
☐	☐	*Heart disease/heart defect/high blood pressure
☐	☐	Chest pain
☐	☐	*Seizures/epilepsy/fainting spells
☐	☐	*Diabetes
☐	☐	*Concussion or serious head injury
☐	☐	*Major surgery or serious illness
☐	☐	Heat stroke/exhaustion
☐	☐	*Blindness/visual problem
☐	☐	Hearing impaired
☐	☐	Deaf/complete hearing loss

YES	NO	
☐	☐	Bone or joint problem
☐	☐	*Asthma
☐	☐	Tobacco Use
☐	☐	Easy bleeding
☐	☐	Emotional/psychiatric/behavioral

If yes, explain: _____

YES	NO	
☐	☐	Sickle cell trait or disease
☐	☐	Immunizations up to date

Date of most recent tetanus immunization: __ /__ /__

YES	NO	
☐	☐	Down Syndrome

YES	NO	
☐	☐	Allergies:

Medicines:_____
Food:_____
Insect Stings/Bites: _____

YES	NO	
☐	☐	Special Diet _____
☐	☐	Other:

_____

(*) Requires physical examination if significant in athlete's health.

MEDICATIONS

Please print medication name, amount, date prescribed and number of times per day medication are given. Use separate sheet for additional space.

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

Physician'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?
☐	☐	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: _____ lbs. 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.

RESTRICTIONS: _____

►**PHYSICIAN'S SIGNATURE:** _____ **Print Physician's Name:** _____ ►**DATE:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

SPECIAL OLYMPICS – Created by the Joseph P. Kennedy Jr. Foundation. Authorized and Accredited by Special Olympics, Inc. for the Benefit of Persons with Intellectual Disabilities.

REVISED JANUARY 2014

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FORM IS VALID FOR THREE (3) YEARS FROM DATE OF PHYSICAL EXAM.

SECTION A: RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics.

- I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical professional has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence that would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction or I have had a full radiological examination that establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer).
- Special Olympics has my permission forever to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.
- I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program 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 understand there is no obligation for me to participate in the Healthy Athletes Program and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health.
- I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.
- If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for the treatment for any reason, I authorize Special Olympics to take whatever measure it deems necessary to protect my health and well-being, including, if necessary, hospitalization. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE *"SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT"* FORM*)***

I, the Athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature of Adult Athlete: _____ Date: _____

I hereby certify that I have reviewed this release with the Athlete whose signature appears above. I am satisfied based on that review that the Athlete understands this release had has agreed to its terms.

Print Name: _____ Date: _____ Relationship to Athlete:_____(e.g. family member, teacher, coach, etc.)

SECTION B: RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of _____, the minor Athlete, on whose behalf I have submitted the attached application for participation in Special Olympics. The Athlete has my permission to participate in Special Olympics activities.

- I further represent and warrant that to the best of my knowledge and belief, the Athlete is physically and mentally able to participate in Special Olympics activities. With my approval, a licensed medical professional has reviewed the health information set forth in the Athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the Athlete's participation. 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 I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction, or the Athlete has had a full radiological examination, which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, the Athlete must have the radiological examination before he/she can participate in judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and football team competition (soccer).
- In permitting the Athlete to participate, I am specifically granting my permission, forever, to Special Olympics to use the Athlete's likeness, name, voice and words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.
- By signing below, I am also permitting the Athlete to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program 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 understand that notwithstanding my consent, there is no obligation for the Athlete to participate in the Healthy Athletes Program and that I may decide that the Athlete will not participate. I understand that the provision of these health services is not intended as a substitute for regular care. I also understand that the Athlete should seek his/her own medical advice and assistance irrespective of the provisions of these services and that Special Olympics through the provision of these services is not making itself responsible for Athlete's health.
- I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.
- If a medical emergency should arise during the Athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the Athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the Athlete is provided with any emergency medical treatment, including hospitalization, that Special Olympics deems advisable in order to protect the Athlete's health and well-being. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE "*SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT*" FORM*)***

I am the parent (guardian) of the Athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the Athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the Athlete named above. I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Guardian: _____ Date: _____