APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND (valid for 3 years)

COUNTY_____ SOC. SEC #_____ DOB _____/_____/_____

☐ FEMALE or ☐ MALE ☐ ATHLETE or ☐ PARTNER ☐ NEW ATHLETE or ☐ CURRENT ATHLETE

ATHLETE INFORMATION

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE (____)_____FAX (____)_____

CELL PHONE (____)_____

E-MAIL _____

HEALTH/ACCIDENT INSURANCE CO _____

POLICY # _____

ETHNICITY (OPTIONAL) CHECK ALL THAT APPLY ☐ CAUCASIAN ☐ ASIAN AMERICAN ☐ AFRICAN AMERICAN ☐ MEXICAN ☐ CARIBBEAN ☐ HISPANIC ☐ OTHER

SCHOOL / AGENCY / EMPLOYER

NAME_____

ADDRESS_____

CITY/STATE/ZIP _____

PHONE (____)_____FAX (____)_____

PARENT / GUARDIAN INFORMATION

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE (____)_____FAX (____)_____

CELL PHONE (____)_____

E-MAIL _____

EMPLOYER

NAME_____

ADDRESS_____

CITY/STATE/ZIP _____

PHONE (____)_____FAX (____)_____

EMERGENCY CONTACT (IF OTHER THAN PARENT)

NAME_____

PHONE (____)_____

CELL PHONE (____)_____

PARENT / GUARDIAN INFORMATION

(*) REQUIRES PHYSICAL EXAM IF NEW PROBLEM

YES	NO		YES	NO	
☐	☐	*HEART DISEASE / HEART DEFECT / HIGH BLOOK PRESSURE	☐	☐	HEAT STROKE / EXHAUSTION
☐	☐	*CHEST PAIN	☐	☐	FALSE TEETH / DENTURES
☐	☐	*SEIZURES / EPILEPSY / FAITING SPELLS	☐	☐	TOBACCO USE
☐	☐	*DIABETES	☐	☐	EASY BELEEDING
☐	☐	*CONCUSSION OR SERIOUS HEAD INJURY	☐	☐	HEARING LOSS / SEVERE HEARING PROBLEM / HEARING AID
☐	☐	*MAJOR SURGERY OR SERIOUS ILLNESS	☐	☐	CONTACT LENSES / GLASSES
☐	☐	*BLINDNESS / SEVERE VISUAL PROBLEM	☐	☐	OTHER HEALTH ISSUES
☐	☐	*ASTHMA	☐	☐	SPECIAL DIET (specify)
☐	☐	SICKLE CELL TRAIT OR DISEASE	☐	☐	ALLERGY TO MEDICINES (specify)
☐	☐	BONE OR JOINT PROBLEM	☐	☐	ALLERGY TO FOOD (specify)
☐	☐	MISSING ONE KIDNEY	☐	☐	ALLERGY TO INSECT STING / BITE (specify)
☐	☐	EMOTIONAL / PSYCHIATRIC / BEHAVIORAL PROBLEM	☐	☐	DATE OF LAST TETANUS SHOT
☐	☐	HEPATITIS	☐	☐	IMMUNIZATIONS UP TO DATE

HAS ATHLETE EVER BEEN CHARGED / CONVICTED OF A CRIMINAL OFFENSE? ☐ YES ☐ NO

HAS ATHLETE EVER BEEN CHARGED WITH ABUSE OF ASSAULT? ☐ YES ☐ NO

DOES ATHLETE HAVE ANY PENDING CRIMINAL CASES? ☐ YES ☐ NO

IS ATHLETE NOW ON PROBATION FOR ANY CRIMINAL OR TRAFFIC VIOLATION? ☐ YES ☐ NO

HAS ATHLETE EVER BEEN FOUND "NOT CRIMINALLY RESPONSIBLE" FOR ANY CRIMINAL OR TRAFFIC OFFENSE? ☐ YES ☐ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN THE DATES AND DETAILS OF EACH CASE ON A SEPARATE SHEET OF PAPER

MEDICATIONS

NAME OF MEDICATION	DOSAGE (MM)	TIMES PER DAY	DATE OF PRESCRIPTION

SIGN

SIGNATURE – PLEASE SIGN BELOW TO INDICATE THAT ALL OF THE ABOVE INFORMATION IS CORRECT, ACCURATE AND UP-TO-DATE

SIGNATURE OF PARENT/GUARDIAN/ADULT ATHLETE _____DATE _____/_____/_____

PLEASE COMPLETE SIDE 2 OF THIS APPLICATION

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND / SIDE TWO

PHYSICAL EXAMINATION

ATHLETE NAME _____

BLOOD PRESSURE _____ HEIGHT _____ft _____inches WEIGHT_____lbs

PREIMARY MR ETIOLOGY/CATEGORY_____ IF PREGNANT, DUE DATE _____/_____/_____

NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL	
☐	☐	VISION	☐	☐	GARDIOVASCULAR SYSTEM	☐	☐	RESPIRATORY SYSTEM	☐	☐	NECK
☐	☐	HEARING	☐	☐	GENITOURINARY SYSTEM	☐	☐	CRANIAL NERVES	☐	☐	SKIN
☐	☐	ORAL CAVITY	☐	☐	GASTROINTESTNAL SYSTEM	☐	☐	COORDINATION	☐	☐	REFLEXES
☐	☐	EXTREMITIES									

COMMENTS _____

_____

RESTRICTIONS _____

I AM A LICENSED MEDICAL PROFESSIONAL. I HAVE REVIEWED THE ACCOMPANYING HEALTH INFORMATION AND HAVE PERFORMED THE ABOVE EXAMINATION ON THIS ATHLETE WITHIN THE LAST 6 MONTHS AND CERTIFY THAT THE ATHLETE CAN PARTICIPATE IN SPECIAL OLYMPICS.

EXAMINER'S NAME _____ PHONE (_____)_____

ADDRESS _____

CITY/STATE/ZIP _____

EXAMINER'S SIGNATURE _____ DATE _____/_____/_____

FOR ATHLETES WITH DOWN SYNDROME

PERSONS WITH DOWN SYNDROME MUST HAVE A LATERAL X-RAY OF THE CERVICAL SPINE IN PYPERFLEXSION AND HYPEREXTENSION. THE INTERPRETATION OF THE RADIOGRAPHYS MUST INCLUDE MEASUREMENTS OF THE ATLANTO-DENS INTERVAL.

YES	NO		YES	NO	
☐	☐	HAS AN X-RAY EVALUATION FOR ATLANTOAXIAL INSTABILITY BEEN DONE?	☐	☐	IF YES, WAS THE ANTLANTO-DENS INTERVALA 5MM OR MORE?

SIGN

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

I, _____ , am at least 18 years old and have submitted this 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 physician has reviewed the health information contained in my application and has certified based on an independent medical examination, that there is no medical evidence which 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 to my neck or upper spine unless I have a full radiological examination which established the absence of Atlanto-axial instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

Special Olympics has my permission, (both during and anytime after) 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 advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

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 treatment, because of my injuries, I authorize Special Olmics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

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 that I agree to the provisions of this release.

Signature of adult athlete _____ Date _____/_____/_____

SIGN

I herby 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 and has agreed to the provisions of this release.

Name (print) _____Relationship to athlete_____

I am the parent/guardian of _____, the minor athlete, on whose behalf I have submitted this application for participation in Special Olympics. I hereby represent that 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. With my approval, a licensed physician 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 to the neck or upper spine unless the athlete has a full radiological examination which establishes the absence of Atlanto-axial instability. I am aware that the sports events for which this radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after) to special Olympics to use the athlete's likeness, name;, voice, or words in either 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 those purposes and activities.

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 to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

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 herein.

I hereby give my permission for the athlete named above to participate in Special Olympics Games, recreation programs and physical activity programs.

SIGN

Signature of Parent/Guardian _____ Date _____/_____/_____

Name (print) _____