

Directions for Completing

Athlete Registration Form, Athlete Release Form & Athlete Medical Forms.

I. If your computer supports Adobe Fillable Forms:

- A. You will complete the following fillable forms:
 - 1. Registration Form
 - 2. Athlete Release Form. (If the athlete does not have a court-appointed legal guardian, the athlete must sign the form.)
 - 3. Page 1 of Athlete Medical Form – HEALTH HISTORY
 - 4. Page 2 of Athlete Medical Form – HEALTH HISTORY
- B. Stop here. Pages 3 & 4 of the Athlete Medical Form are the PHYSICAL EXAM and must be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medication.
- C. Print all pages and take them with you to your athlete's exam.
- D. When all pages are complete and signed, make a copy of them, and mail or bring the originals to:
Pam Hollaway, 123 Brooks St. Sugar Land, TX 77478

II. If your computer does not support Adobe Fillable Forms:

- A. Download and print all of the forms. (6 pages total)
- B. You will fill out the following forms. Please PRINT
 - a. Registration Form
 - b. Athlete Release Form. (If the athlete does not have a court-appointed legal guardian, the athlete must sign the form.)
 - c. Page 1 of Athlete Medical Form – HEALTH HISTORY
 - d. Page 2 of Athlete Medical Form – HEALTH HISTORY
- C. Stop here. Pages 3 & 4 of the Athlete Medical Form are the PHYSICAL EXAM and must be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medication.
- D. Print all pages and take them with you to your athlete's exam.
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ATHLETE REGISTRATION FORM

Special Olympics



State Special Olympics Program: _____

Are you a new athlete to Special Olympics or Re-Registering? New Athlete Re-Registering

ATHLETE INFORMATION		
First Name:	Middle Name:	
Last Name:	Preferred Name:	
Date of Birth (mm/dd/yyyy):	Female	Male
Race/Ethnicity (Optional):		
American Indian/Alaskan Native	Asian	Two or More Races
Black or African American	Native Hawaiian or Other Pacific Islander	
White	Hispanic or Latino (specific origin group: _____)	
Language(s) Spoken in Athlete's Home (Optional): Check all that apply		
English	Spanish	Other (please list):
Street Address:		
City:	State:	Postal Code:
Phone:	E-mail:	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? Yes No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
Same Contact Info as Athlete		
Street Address:		
City:	State:	Postal Code:
Phone:	E-mail:	
EMERGENCY CONTACT INFORMATION		
Same as Parent/Guardian		
Name:		
Phone:	Relationship:	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	Insurance Policy Number:	
Insurance Group Number:		

ATHLETE RELEASE FORM

Special Olympics



I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
 - I have a religious or other objection to receiving medical treatment. (Not common.)
 - I do not consent to blood transfusions. (Not common.)
 (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
 - I agree and consent to Special Olympics:
 - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
 - using my personal information and creating a profile of me for communications and marketing purposes, including direct digital marketing through email, SMS, social media, and other channels.
 - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
 - I understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
 - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
 - *Sharing of Personal Information.* Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy_Policy.aspx.

Athlete Name:	E-mail:
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	Date:
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	Date:
Printed Name:	Relationship:

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

**Special
Olympics**



Athlete First & Last Name: _____ Preferred Name: _____

Athlete Date of Birth (mm/dd/yyyy): _____ Female Male

STATE PROGRAM: _____ E-mail: _____

ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

Autism	Down Syndrome	Fragile X Syndrome
Cerebral Palsy	Fetal Alcohol Syndrome	
Other Syndrome, please specify: _____		

ALLERGIES & DIETARY RESTRICTIONS

No Known Allergies
Latex
Medications: _____
Insect Bites or Stings: _____
Food: _____

ASSISTIVE DEVICES - Does the athlete use (check any that apply):

Brace	Colostomy	Communication Device
C-PAP Machine	Crutches or Walker	Dentures
Glasses or Contacts	G-Tube or J-Tube	Hearing Aid
Implanted Device	Inhaler	Pacemaker
Removable Prosthetics	Splint	Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

No Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?

No Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*

Yes, had abnormal EKG

Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? No Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder No Yes

If yes, list seizure type: _____

If yes, had seizure during the past year? No Yes

MENTAL HEALTH

Self-injurious behavior during the past year No Yes Depression (diagnosed) No Yes

Aggressive behavior during the past year No Yes Anxiety (diagnosed) No Yes

Describe any additional mental health concerns:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? No Yes

Has any family member or relative died while exercising? No Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)



Athlete's First and Last Name: _____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	No	Yes	High Blood Pressure	No	Yes	Stroke/TIA	No	Yes
Dizziness during or after exercise	No	Yes	High Cholesterol	No	Yes	Concussions	No	Yes
Headache during or after exercise	No	Yes	Vision Impairment	No	Yes	Asthma	No	Yes
Chest pain during or after exercise	No	Yes	Hearing Impairment	No	Yes	Diabetes	No	Yes
Shortness of breath during or after exercise	No	Yes	Enlarged Spleen	No	Yes	Hepatitis	No	Yes
Irregular, racing or skipped heart beats	No	Yes	Single Kidney	No	Yes	Urinary Discomfort	No	Yes
Congenital Heart Defect	No	Yes	Osteoporosis	No	Yes	Spina Bifida	No	Yes
Heart Attack	No	Yes	Osteopenia	No	Yes	Arthritis	No	Yes
Cardiomyopathy	No	Yes	Sickle Cell Disease	No	Yes	Heat Illness	No	Yes
Heart Valve Disease	No	Yes	Sickle Cell Trait	No	Yes	Broken Bones	No	Yes
Heart Murmur	No	Yes	Easy Bleeding	No	Yes	Dislocated Joints	No	Yes
Endocarditis	No	Yes	If female athlete, list date of last menstrual period: _____					

Describe any past broken bones or dislocated joints

(if yes is checked for either of those fields above):

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

Difficulty controlling bowels or bladder	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Numbness or tingling in legs, arms, hands or feet	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Weakness in legs, arms, hands or feet	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Head Tilt	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Spasticity	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes
Paralysis	No	Yes	<i>If yes, is this new or worse in the past 3 years?</i>	No	Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day

Is the athlete able to administer his or her own medications? No Yes

Name of Person Completing this Form	Relationship to Athlete	Phone	Email
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Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)



Athlete's First and Last Name: _____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI (optional)	Temperature	Pulse	O ₂ Sat	Blood Pressure (in mmHg)		Vision				
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better	No	Yes	N/A	
in	lbs	Body Fat %	F					Left Vision 20/40 or better	No	Yes	N/A	
Right Hearing (Finger Rub)	Responds	No Response	Can't Evaluate			Bowel Sounds	Yes	No				
Left Hearing (Finger Rub)	Responds	No Response	Can't Evaluate			Hepatomegaly	No	Yes				
Right Ear Canal	Clear	Cerumen	Foreign Body			Splenomegaly	No	Yes				
Left Ear Canal	Clear	Cerumen	Foreign Body			Abdominal Tenderness	No	RUQ	RLQ	LUQ	LLQ	
Right Tympanic Membrane	Clear	Perforation	Infection	NA		Kidney Tenderness	No	Right	Left			
Left Tympanic Membrane	Clear	Perforation	Infection	NA		Right upper extremity reflex	Normal	Diminished	Hyperreflexia			
Oral Hygiene	Good	Fair	Poor			Left upper extremity reflex	Normal	Diminished	Hyperreflexia			
Thyroid Enlargement	No	Yes				Right lower extremity reflex	Normal	Diminished	Hyperreflexia			
Lymph Node Enlargement	No	Yes				Left lower extremity reflex	Normal	Diminished	Hyperreflexia			
Heart Murmur (supine)	No	1/6 or 2/6	3/6 or greater			Abnormal Gait	No	Yes, describe below				
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater			Spasticity	No	Yes, describe below				
Heart Rhythm	Regular	Irregular				Tremor	No	Yes, describe below				
Lungs	Clear	Not clear				Neck & Back Mobility	Full	Not full, describe below				
Right Leg Edema	No	1+ 2+ 3+ 4+				Upper Extremity Mobility	Full	Not full, describe below				
Left Leg Edema	No	1+ 2+ 3+ 4+				Lower Extremity Mobility	Full	Not full, describe below				
Radial Pulse Symmetry	Yes	R>L	L>R			Upper Extremity Strength	Full	Not full, describe below				
Cyanosis	No	Yes, describe				Lower Extremity Strength	Full	Not full, describe below				
Clubbing	No	Yes, describe				Loss of Sensitivity	No	Yes, describe below				

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)

Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability. **OR**

Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

ATHLETE CLEARANCE TO PARTICIPATE (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

This athlete is **ABLE** to participate in Special Olympics sports without restrictions.

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe → _____

This athlete **MAY NOT participate** in Special Olympics sports at this time & **MUST** be further evaluated by a physician for the following concerns:

- | | | |
|------------------------------|----------------------------------|---|
| Concerning Cardiac Exam | Acute Infection | O ₂ Saturation Less than 90% on Room Air |
| Concerning Neurological Exam | Stage II Hypertension or Greater | Hepatomegaly or Splenomegaly |
| Other, please describe: | | |

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- | | | |
|------------------------------------|-------------------------------------|--|
| Follow up with a cardiologist | Follow up with a neurologist | Follow up with a primary care physician |
| Follow up with a vision specialist | Follow up with a hearing specialist | Follow up with a dentist or dental hygienist |
| Follow up with a podiatrist | Follow up with a physical therapist | Follow up with a nutritionist |

Other/Exam Notes:

	Name:
	E-mail:
Signature of Licensed Medical Examiner	Phone:
Exam Date	License #:

Athlete Medical Form – MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed)



Athlete's First and Last Name: _____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name: _____

Specialty: _____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

Concerning Cardiac Exam Acute Infection O₂ Saturation Less than 90% on Room Air

Concerning Neurological Exam Stage II Hypertension or Greater Hepatomegaly or Splenomegaly

Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):		
Yes	Yes, but with restrictions (<i>list below</i>)	No

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

License: _____

Examiner's Signature	Date
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This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event?	Yes	No
The athlete is a Unified Partner or a Young Athlete Participant?	Unified Partner	Young Athlete