

Application for Participation
SECTION A - ATHLETE HEALTH INFORMATION

SOTN 7-30-2008

Area Program _____ Sex/Gender M F
Athlete Name _____ Date of Birth (month, day, year) _____
Address _____
Address 2 _____ Home Phone _____
City _____ State _____ Zip _____ Email Address _____
Parents/Guardian Name _____ Home Phone _____
Address (If different from athlete) _____ Work Phone _____
Address 2 _____ Cell Phone _____
City _____ State _____ Zip _____ Email Address _____
Emergency Contact (if other than parent/guardian) _____ Home Phone _____
_____ Cell Phone _____
Health/Accident Company _____ Policy # _____

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

Athletes must have a physical examination every three (3) years performed by a physician or a licensed examiner or nurse practitioner working under the supervision of a physician.

SECTION B - MEDICAL CERTIFICATION AND SIGNATURE

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 a radiological examination is required are: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football team competition (soccer).

I have reviewed the above health information on and examined the athlete named in the application, and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

RESTRICTIONS _____
EXAMINER'S SIGNATURE _____ DATE _____
EXAMINER'S NAME (PRINT CLEARLY) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ PHONE _____

SECTION C - COMMENTS, MEDICATIONS, PARENT/GUARDIAN/ATHLETE SIGNATURE

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 Health Information in Section A is completed by adult athlete-I have reviewed the health history with the athlete whose signature appears above.

Signature _____ Date _____ Relationship to Athlete _____

IMPORTANT: If at any time there is any significant change in the athlete's health, the athlete's condition should be reviewed by a licensed examiner before further participation.