

# ATHLETE REGISTRATION FORM

Special Olympics



State Special Olympics Program: \_\_\_\_\_ Local Area/Delegation: \_\_\_\_\_

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  Other Gender Identity

Race/Ethnicity:

Prefer not to answer

American Indian/Alaskan Native

Asian American

More than one race

Black or African American

Native Hawaiian or Other Pacific Islander

White or Caucasian

Hispanic or Latinx

Language(s) Spoken in Athlete's Home (Optional): Check all that apply

English  Spanish  Other (please list):

Street Address:

City:

State:

Zip 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:

Zip 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 LIKENESS RELEASE FOR SPONSORS

**Special Olympics**



**Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below.**

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively “Special Olympics”) and their sponsors and partners to use my likeness, photo, video, name, voice, words, and biographical information (“my likeness”) to acknowledge the sponsors’ and partners’ support for Special Olympics.
- Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
- I understand I will not be compensated for the use of my Likeness.

<b>Athlete Name:</b>	
<b>ATHLETE SIGNATURE</b> (required for adult athlete with capacity to sign legal documents)	
<b>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</b>	
<b>Athlete Signature:</b>	<b>Date:</b>
<b>PARENT/GUARDIAN SIGNATURE</b> (required for athlete who is a minor or lacks capacity to sign legal documents)	
<b>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.</b>	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>

# 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, words, and biographical information 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 contact information for communicating with me about Special Olympics.
    - sharing my personal information confidentially with (i) researchers such as universities and public health agencies 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 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.
  - *Privacy Policy.* Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at [www.SpecialOlympics.org/Privacy-Policy](http://www.SpecialOlympics.org/Privacy-Policy).

<b>Athlete Name:</b>	
<b>ATHLETE SIGNATURE</b> (required for adult athlete with capacity to sign legal documents)	
<b>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</b>	
<b>Athlete Signature:</b>	<b>Date:</b>
<b>PARENT/GUARDIAN SIGNATURE</b> (required for athlete who is a minor or lacks capacity to sign legal documents)	
<b>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.</b>	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>



## **CONCUSSION AWARENESS AND SAFETY RECOGNITION POLICY**

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### **Objective**

It is Special Olympics' intent to take steps to help ensure the health and safety of all Special Olympics participants. All Special Olympics participants should remember that safety comes first and should take reasonable steps to help minimize the risks for concussion or other serious brain injuries.

### **Defining a Concussion**

A concussion is defined by the Centers for Disease Control as a type of traumatic brain injury caused by a bump, blow, or jolt to the head as well as serial, cumulative hits to the head. Concussions can also occur from a blow to the body that causes the head and brain to move quickly back and forth—causing the brain to bounce around or twist within the skull. Although concussions are usually not life-threatening, their effects can be serious and therefore proper attention must be paid to individuals suspected of sustaining a concussion.

### **Suspected or Confirmed Concussion**

A participant who is suspected of sustaining a concussion in a practice, game or competition shall be removed from practice, play or competition at that time. If a qualified medical professional is available on-site to render an evaluation, that person shall have final authority as to the removal or return to play of the participant. If applicable, the participant's parent or guardian should be made aware that the participant is suspected of sustaining a concussion.

### **Return to Play**

A participant who has been removed from practice, play or competition due to a suspected concussion may not participate in Special Olympics sports activities until either of the following occurs (1) at least seven (7) consecutive days have passed since the participant was removed from play and a currently licensed, qualified medical professional provides written clearance for the participant to return to practice, play and competition or (2) a currently licensed, qualified medical professional determines that the participant did not suffer a concussion and provides written clearance for the participant to return to practice play immediately. Written clearance in either of the scenarios above shall become a permanent record.

The Centers for Disease Control website [www.cdc.gov/concussion](http://www.cdc.gov/concussion) provides additional resources relative to concussions that may be of interest to participants and their families.

# 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	If yes, is this new or worse in the past 3 years?	No	Yes
Numbness or tingling in legs, arms, hands or feet	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Weakness in legs, arms, hands or feet	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Head Tilt	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Spasticity	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Paralysis	No	Yes	If yes, is this new or worse in the past 3 years?	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 <sub>2</sub> 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<sub>2</sub> 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:	
<b>Signature of Licensed Medical Examiner</b>	Exam Date	Phone:	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      O<sub>2</sub> 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 (*list below*)**

**No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: \_\_\_\_\_

Examiner Phone: \_\_\_\_\_

License: \_\_\_\_\_

**Examiner's Signature**

**Date**

**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