

SPECIAL OLYMPICS OKLAHOMA APPLICATION FOR PARTICIPATION

Application valid September 1, 2007 through August 31, 2010

→ Print or Type Information on Form & Fill-in Completely ← SECTION A - ATHLETE INFORMATION

Athlete Name (First - Last) _____

Date of Birth - Month / Day / Year _____ / _____ / _____ Sex: Male Female

African American Caucasian Hispanic Native American Asian Other

Area Name & City _____

2007 -'08 – Coach / Team _____ Phone _____

2008 -'09 - Coach / Team _____ Phone _____

2009 -'10 - Coach / Team _____ Phone _____

Athlete's Parent / Guardian _____ Phone _____

Emergency Contact Name _____ Phone _____

Health/Medical Insurance Co. _____ Policy # _____

SECTION B - HEALTH HISTORY INFORMATION

Check Yes or No	YES	NO	Check Yes or No	YES	NO
1 – Heart disease/defect/High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	14 – Heat stroke/Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
2 – Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	15 – Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
3 – Seizures/Epilepsy/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	16 – Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
4 – Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	17 – Emotional/psychiatric/behavioral	<input type="checkbox"/>	<input type="checkbox"/>
5 – Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	18 – Sickle cell disease/trait	<input type="checkbox"/>	<input type="checkbox"/>
6 – Atlantoaxial X-ray evaluation	<input type="checkbox"/>	<input type="checkbox"/>	19 – Immunizations up-to-date	<input type="checkbox"/>	<input type="checkbox"/>
7 – Blindness / visual problems	<input type="checkbox"/>	<input type="checkbox"/>	20 – Allergy: _____	<input type="checkbox"/>	<input type="checkbox"/>
8 – Eyeglasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	21 – To Medicines: List below if Yes	<input type="checkbox"/>	<input type="checkbox"/>
9 – Hearing impairment/Deafness	<input type="checkbox"/>	<input type="checkbox"/>	22 – To Food: List below if Yes	<input type="checkbox"/>	<input type="checkbox"/>
10 - Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	23 – To Insect bites/stings: List below if Yes	<input type="checkbox"/>	<input type="checkbox"/>
11 – Recent contagious disease/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	24 – Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
12 – Bone or joint problems	<input type="checkbox"/>	<input type="checkbox"/>	25 – X-ray done to check Instability?	<input type="checkbox"/>	<input type="checkbox"/>
13 – Date of last Tetanus ----- / ----- / -----	<input type="checkbox"/>	<input type="checkbox"/>	26 – Was x-ray positive for Instability?	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

SECTION C - MEDICATIONS

List medications & dosages the Athlete is currently taking: **PLEASE PRINT NEATLY - & KEEP UPDATED**

Medication Name	Dosage	Prescription Date	Times Per Day

ALLERGIES TO MEDICATIONS – FOODS – INSECT BITES or STINGS

NOTE TO PARENTS/GUARDIANS: It is the responsibility of the Parent/Guardian to complete & keep Sections B & C updated & accurate concerning changes in health status and all medication information.

SECTION D – MEDICAL CERTIFICATION

NAME OF ATHLETE _____ Date _____

NOTE TO PHYSICIAN: If the athlete has Down Syndrome, Special Olympics requires that the athlete have a full radiological exam establishing the presence or absence of Atlantoaxial Instability before he/she may participate.

CHECK: I have reviewed the health information on & examined the athlete named in the application & certify that the athlete can participate in Special Olympics. Down Syndrome & other athletes' caregivers have been advised of any medical restrictions.

Blood Pressure _____ / _____	Weight _____	Height _____	
Normal Abnormal	Normal Abnormal	Normal Abnormal	Normal Abnormal
Vision <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Cardiovascular system <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Cranial nerves <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
Hearing <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Respiratory system <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Coordination <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
Oral Cavity <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Gastrointestinal system <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Reflexes <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
Neck <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Genitourinary system <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>		
Extremities <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>			

RESTRICTIONS: _____

* **SOOK physicals may be done & signed by Physicians, Physician Assts., Nurse Practitioners or Clinical Nurse Specialists.**

MEDIC'S NAME (PRINT) _____ Phone _____

MEDIC'S SIGNATURE _____ Date _____

This form must have an approved medical signature in Section D to be valid.

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

RELEASE TO BE COMPLETED BY

PARENT / GUARDIAN OR 18 YR. OLD ADULT ATHLETE ACTING AS OWN LEGAL GUARDIAN

I, the Parent / Guardian OR the 18 yr. old Adult Athlete submit this Application for Participation in Special Olympics.

I 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. I also represent that a licensed physician has reviewed the health information contained in this application and has certified, based on a medical examination, that there is no medical evidence which would preclude the athlete from participating in Special Olympics. I understand that if the athlete has Down Syndrome, the athlete 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 the athlete and physician have completed the official "Down Addendum Form", available from the Special Olympics State office. I am aware that the x-ray exam is required before any athlete with Down Syndrome may participate in Special Olympics, especially in the following: equestrian, 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 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, during the athlete's participation in Special Olympics activities, the athlete should need emergency medical treatment, and I (the parent/guardian or adult athlete) am not able to give consent or make arrangements for that treatment, I authorize Special Olympics to take whatever measures necessary to protect the athlete's health and well-being, including, if necessary, hospitalization.

By signing below, I consent to the athlete's participation in the Healthy Athlete Program. I understand that I should seek independent medical advice and assistance as I am responsible for the athlete's health. I understand that information gathered as part of the screening process may be used anonymously to assess and communicate overall health and needs of athletes and to develop programs to address those needs.

I, the adult athlete, 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.

I, the parent / guardian of this athlete, hereby give my permission for this athlete to participate in Special Olympics games, training, recreation programs, physical activity programs and Healthy Athletes program. By signing, I am saying that I agree to the provisions of this release.

Signature of Parent/Guardian _____ Date _____

Address / City / Zip _____

Phones (W) _____ (H) _____ (Cell) _____

Signature of Adult Athlete _____ Phone _____

Address / City / Zip _____

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 and has agreed to its terms.

Name (print) _____ Relationship _____

Special Olympics Coach:

Here is the new 3-year medical/release form **valid Sept., 2007 through Aug., 2010**. All athletes who plan to compete in any Special Olympics Oklahoma events in that time period must have this form completed.

- ✚ This is a very important document. Print or Type the information and make sure it is legible. When you make copies of this form – make sure all information is legible on the copy.
- ✚ If forms are received that are NOT legible – they will be returned to the Coach. If you can't read all the information, neither can our medical personnel!
- ✚ **ALL** information must be completed. Don't skip over any requested information – all information must be completed to make this form valid. **COMPLETE EVERYTHING!**
- ✚ This form is valid for a 3-year period. Be sure to make copies to submit with event registration and keep the Original form on file.
- ✚ This form is **NOT** kept on file with your Area or at the State Office. It is *your* responsibility as a Coach to keep the Original and submit copies with each event registration.
- ✚ As a Coach, it is also your responsibility to work with parents/guardians to ensure that medical information is updated as needed – including updating Section C – Medications.
- ✚ This med/release form is required for every Special Olympics Athlete to compete. We do **not** accept any other med/release forms – such as OSSAA. They don't accept ours – we don't accept theirs.
- ✚ Work with parents/guardians to ensure that this form is completed well before any competition event in which the athlete will participate. A copy of this form is required to be sent with any Area, Sectional or State competition registration and *must* be received prior to any event.
- ✚ Athletes with Down Syndrome must have a Downs Addendum completed and on file here at the State Office in Tulsa. It requires an x-ray and diagnosis by a doctor. * *You may call our office to confirm whether we have a certain athlete's Addendum on file.*

Coach – Remember this is a very important document!

- * Print or Type all information & make sure your copies are legible.
 - * If this form isn't legible – it will be returned to you.
 - * Work with parents to keep all medical information up-to-date.
- * *You* keep the Original & submit copies with all competition registrations.
- * The 2004 – 2007 meds will be accepted for Area Bowling events **only**. For all other events, the new 2007 – 2010 form will be required.