Special Olympics Massachusetts

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

## BASIC INFORMATION

Section (North/South/West)_____Local Program (Number/Name) _____

Name

Male Female

Race Ethnicity (Optional)

Black White Hispanic Asian/Pacific Islander American Indian Other

Date of Birth

Street Address or PO Box

Apt #

City/Town

State

ZIP Code + 4

Home Phone #

Email Address – Athlete or Family (circle one)

Parent/Guardian's Name

Home Phone #

Emergency Contact (if other than parent/guardian)

Emergency Contact Cell Phone #

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Health/Accident Insurance Company _____ Policy # _____

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Heart disease / heart defect / high blood pressure | ☐ | ☐ | Allergy: |
| ☐ | ☐ | Chest pain | ☐ | ☐ | General: _____ |
| ☐ | ☐ | Seizures / epilepsy/ fainting spells | ☐ | ☐ | Medicines: _____ |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Food: _____ |
| ☐ | ☐ | Concussion or serious head injury | ☐ | ☐ | Insect stings/bites: _____ |
| ☐ | ☐ | Major surgery or serious illness | ☐ | ☐ | Special diet: _____ |
| ☐ | ☐ | Heat stroke / exhaustion | ☐ | ☐ | Asthma |
| ☐ | ☐ | Blindness / visual problem | ☐ | ☐ | Emotional/psychiatric/behavioral/requires extra supervision |
| ☐ | ☐ | Contact lenses / glasses | | | Description: _____ |
| ☐ | ☐ | Hearing loss / hearing aid | ☐ | ☐ | Immunizations up to date |
| ☐ | ☐ | Bone or joint problem | ☐ | ☐ | Other: _____ |
| ☐ | ☐ | Currently on Medication *(If yes, please bring current list with you to each competition)* | ☐ | ☐ | Down syndrome **(see below)** |
| | | | | | Date of most recent tetanus immunization____/____/____ |

Special Olympics Massachusetts (SOMA) specifically has my permission (both during participation and anytime thereafter) to use my/my child's/my ward's likeness, name, voice, and words in television, radio, film, newspaper, magazines, and any other media, and in any form, for the purpose of advertising or communicating the purposes and activities of SOMA; as well as participation in Healthy Athletes, as outlined by the enclosed 'Healthy Athletes Consent Form'.

I understand that if a medical emergency should arise during my/my child's/my ward's participation in any SOMA activity and I am not able to give my consent to treatment, that SOMA is authorized to take whatever measures are necessary to protect my health and well-being including hospitalization.

**Signature of parent/caregiver/adult athlete (over 18):** **Date:** _____/_____/_____

## ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: SOMA requires persons with Down syndrome to have 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.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Has an x-ray evaluation for atlanto-axial instability been done? Date of x-ray: _____/_____/_____ |
| ☐ | ☐ | If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more) |

## PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTHY CARE PROVIDER

Primary MR Etiology/Category: (If known) _____

**I have reviewed the above health information and have performed the above examination on this athlete and certify that the athlete can participate in Special Olympics.**

**RESTRICTIONS:** _____

**EXAMINER'S SIGNATURE:** _____ **Exam Date** _____/_____/_____

(*no office stamps accepted without provider's signature)*

Examiner's Name

Street Address or P.O.

City/Town State ZIP Phone #

A COPY OF THIS APPLICATION MUST BE WITH YOUR COACH AT ALL TRAININGS AND COMPETITIONS AND FILED AT THE SOMA HEADQUARTERS & SECTION OFFICE

Last update: 9/09

# Healthy Athlete CONSENT FORM

Special Olympics offers certain non-invasive health care services to athletes at local, state, national, and World Games venues through the Healthy Athletes Program. These services may include individual screening assessments of health status and health care needs, provision of health education, routine preventive services (e.g. protective mouth guards), educational services, and, in the case of vision and hearing deficits, provision of needed eyewear (glasses, swim goggles, protective eyewear) and hearing aids. Athletes are informed as to their health status and advised of the need for follow-up care. In addition, information collected at the time services are provided has been invaluable for developing policies, securing resources, and implementing programs to better meet the health needs of athletes.

I understand that by signing the attached medical form I consent to participate in the Special Olympics Healthy Athletes program that provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand there is no obligation for me to participate in the Healthy Athletes Program should I decide no to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

**Authorization for Minors:** I understand that by signing the attached form, I consent to my child's/dependent's participation in the Special Olympics Healthy Athletes program that provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand there is no obligation for the athlete named above to participate in the Healthy Athletes Program should the athlete decide not to participate or should I decide the athlete shall not participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services for the athlete named above and that Special Olympics is not through the provision of these provisions responsible for the health of the athlete named above. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.