

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND (valid for 3 years)

COUNTY \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

FEMALE or  MALE  ATHLETE or  PARTNER  NEW ATHLETE or  CURRENT ATHLETE

## ATHLETE INFORMATION

NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY/STATE/ZIP \_\_\_\_\_  
 HOME PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
 CELL PHONE (\_\_\_\_) \_\_\_\_\_  
 EMAIL \_\_\_\_\_  
 HEALTH/ACCIDENT INSURANCE CO \_\_\_\_\_  
 POLICY # \_\_\_\_\_  
 ETHNICITY (OPTIONAL) CHECK ALL THAT APPLY  CAUCASIAN  ASIAN AMERICAN  
 AFRICAN AMERICAN  MEXICAN  CARIBBEAN  HISPANIC OTHER \_\_\_\_\_

## SCHOOL / AGENCY / EMPLOYER

NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY/STATE/ZIP \_\_\_\_\_  
 PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

## PARENT / GUARDIAN INFORMATION

NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY/STATE/ZIP \_\_\_\_\_  
 HOME PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
 CELL PHONE (\_\_\_\_) \_\_\_\_\_  
 EMAIL \_\_\_\_\_

## EMPLOYER

NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY/STATE/ZIP \_\_\_\_\_  
 PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

## EMERGENCY CONTACT (IF OTHER THAN PARENT)

NAME \_\_\_\_\_  
 PHONE (\_\_\_\_) \_\_\_\_\_  
 CELL PHONE (\_\_\_\_) \_\_\_\_\_

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

<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> *HEART DISEASE / HEART DEFECT / HIGH BLOOD PRESSURE</p> <p><input type="checkbox"/> <input type="checkbox"/> *CHEST PAIN</p> <p><input type="checkbox"/> <input type="checkbox"/> *SEIZURES / EPILEPSY / FAINTING SPELLS</p> <p><input type="checkbox"/> <input type="checkbox"/> *DIABETES</p> <p><input type="checkbox"/> <input type="checkbox"/> *CONCUSSION OR SERIOUS HEAD INJURY</p> <p><input type="checkbox"/> <input type="checkbox"/> *MAJOR SURGERY OR SERIOUS ILLNESS</p> <p><input type="checkbox"/> <input type="checkbox"/> *BLINDNESS / SEVERE VISUAL PROBLEM</p> <p><input type="checkbox"/> <input type="checkbox"/> *ASTHMA</p> <p><input type="checkbox"/> <input type="checkbox"/> SICKLE CELL TRAIT OR DISEASE</p> <p><input type="checkbox"/> <input type="checkbox"/> BONE OR JOINT PROBLEM</p> <p><input type="checkbox"/> <input type="checkbox"/> MISSING ONE KIDNEY</p> <p><input type="checkbox"/> <input type="checkbox"/> MISSING ONE TESTICLE</p> <p><input type="checkbox"/> <input type="checkbox"/> EMOTIONAL / PSYCHIATRIC / BEHAVIORAL PROBLEM</p> <p><input type="checkbox"/> <input type="checkbox"/> HEPATITIS</p> <p><input type="checkbox"/> <input type="checkbox"/> HEAT STROKE / EXHAUSTION</p>	<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> FALSE TEETH/DENTURES</p> <p><input type="checkbox"/> <input type="checkbox"/> TOBACCO USE</p> <p><input type="checkbox"/> <input type="checkbox"/> EASY BLEEDING</p> <p><input type="checkbox"/> <input type="checkbox"/> HEARING LOSS / SEVERE HEARING PROBLEM / HEARING AID</p> <p><input type="checkbox"/> <input type="checkbox"/> CONTACT LENSES / GLASSES</p> <p><input type="checkbox"/> <input type="checkbox"/> OTHER HEALTH ISSUES: _____</p> <p>_____</p> <p><input type="checkbox"/> <input type="checkbox"/> SPECIAL DIET (specify) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> ALLERGY TO MEDICINES (specify) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> ALLERGY TO FOOD (specify) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> ALLERGY TO INSECT STING/BITE (specify) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> DATE OF LAST TETANUS SHOT _____</p> <p><input type="checkbox"/> <input type="checkbox"/> IMMUNIZATIONS UP TO DATE _____</p> <p><b>(*) REQUIRES PHYSICAL EXAM IF NEW PROBLEM</b></p>
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HAS ATHLETE EVER BEEN CHARGED/CONVICED OF A CRIMINAL OFFENSE?  YES  NO

HAS ATHLETE EVER BEEN CHARGED WITH ABUSE OR ASSAULT?  YES  NO

DOES ATHLETE HAVE ANY PENDING CRIMINAL CASES?  YES  NO

IS ATHLETE NOW ON PROBATION FOR ANY CRIMINAL OR TRAFFIC VIOLATION?  YES  NO

HAS ATHLETE EVER BEEN FOUND "NOT CRIMINALLY RESPONSIBLE" FOR ANY CRIMINAL OR TRAFFIC OFFENSE?  YES  NO

**IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN THE DATES AND DETAILS OF EACH CASE ON A SEPARATE SHEET OF PAPER**

## MEDICATIONS:

NAME OF MEDICATION	DOSAGE (MM)	TIMES PER DAY	DATE OF PRESCRIPTION

## SIGNATURE

PLEASE SIGN BELOW TO INDICATE THAT ALL OF THE ABOVE INFORMATION IS CORRECT, ACCURATE AND UP-TO-DATE:

SIGNATURE OF PARENT/GUARDIAN/ADULT ATHLETE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ **PLEASE COMPLETE SIDE 2 OF THIS APPLICATION**

**SIGN**

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND / SIDE TWO

## PHYSICAL EXAMINATION:

ATHLETE NAME \_\_\_\_\_  
 BLOOD PRESSURE \_\_\_\_\_ HEIGHT \_\_\_\_\_ ft. \_\_\_\_\_ inches WEIGHT \_\_\_\_\_ lbs.  
 PRIMARY MR ETIOLOGY/CATEGORY \_\_\_\_\_ IF PREGNANT, DUE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>NORMAL</b>	<b>ABNORMAL</b>	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>NORMAL</b>	<b>ABNORMAL</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	VISION		CARDIOVASCULAR SYSTEM		RESPIRATORY SYSTEM		NECK		EXTREMITIES
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HEARING		GENITOURINARY SYSTEM		CRANIAL NERVES		SKIN		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ORAL CAVITY		GASTROINTESTINAL SYSTEM		COORDINATION		REFLEXES		

COMMENTS \_\_\_\_\_  
 \_\_\_\_\_

RESTRICTIONS: \_\_\_\_\_

I AM A LICENSED MEDICAL PROFESSIONAL. I HAVE REVIEWED THE ACCOMPANYING HEALTH INFORMATION AND HAVE PERFORMED THE ABOVE EXAMINATION ON THIS ATHLETE WITHIN THE LAST 6 MONTHS AND CERTIFY THAT THE ATHLETE CAN PARTICIPATE IN SPECIAL OLYMPICS.

EXAMINER'S NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

A(DDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

EXAMINER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

## FOR ATHLETES WITH DOWN SYNDROME:

PERSONS WITH DOWN SYNDROME MUST HAVE A LATERAL X-RAY OF THE CERVICAL SPINE IN HYPERFLEXION AND HYPEREXTENSION. THE INTERPRETATION OF THE RADIOGRAPHS MUST INCLUDE MEASUREMENTS OF THE ATLANTO-DENS INTERVAL.

YES NO YES NO  
  HAS AN X-RAY EVALUATION FOR ATLANTOAXIAL INSTABILITY BEEN DONE?   IF YES, WAS THE ATLANTO-DENS INTERVAL 5MM OR MORE?

## OFFICIAL SPECIAL OLYMPICS RELEASE FORM

I, \_\_\_\_\_ am at least 18 years old and have submitted this application for participation in Special Olympics

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down syndrome, I cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure to my neck or upper spine unless I have a full radiological examination which establishes the absence of Atlanto-axial instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, 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 my 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 my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, 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.

Signature of adult athlete \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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 the provisions of this release.

Name (print) \_\_\_\_\_ Relationship to athlete \_\_\_\_\_

**I am the parent/guardian of \_\_\_\_\_, the minor athlete, on whose behalf I have submitted this application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.**

I further represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application and has certified based on an independent medical examination, that there is no medical evidence which would preclude the athlete's participation. I understand that if the athlete has Down syndrome, he/she cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure to the neck or upper spine unless the athlete has a full radiological examination which establishes the absence of Atlanto-axial instability. I am aware that the sports events for which this radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after) to Special Olympics 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 a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

I am the parent/guardian of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named herein.

I hereby give my permission for the athlete named above to participate in Special Olympics Games, recreation programs and physical activity programs

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (print) \_\_\_\_\_

SIGN

SIGN

SIGN

