INSTRUCTIONS

This is a 2-sided **Application for Participation** which includes a medical release and a waiver of liability. This application is good for 3 years* from the date of the exam. All athletes who plan to train and compete in any Special Olympics events must have this completed original form on file with the Special Olympics Vermont office, and a copy with the local program.

- **COMPLETE EVERYTHING.** Don't skip over any requested information – all information must be completed to make this form valid.
- **IMPORTANT & CONFIDENTIAL.** This is a very important document and should be treated as confidential. Print or Type the information and make sure it is legible. If forms are received that are NOT legible – they will be returned to the Program Coordinator.
- **WHO SHOULD HAVE COPIES:** Parents/Guardians - keep a copy for yourself. Coaches – carry a copy with you at all times when you are with the athletes – including practices and games. Program Coordinators –mail the original to the State office and keep a copy in the program files. **Important:** We cannot accept faxes of this document.

- A licensed physician must complete, sign and date. The physician's printed name, address and phone number should appear in the space provided.
- If either the physician's signature ***or*** date is missing the form will be returned.

- **UPDATED INFORMATION.** Program Coordinators should work with parents/guardians to ensure that medical information is updated as needed – including updating Section C – Medications.
- **REQUIRED FORM.** This application form is required for every Special Olympics athlete to train and compete. .
- Athletes with **Down Syndrome** must have an Atlanto-Axial Instability Section of the Application for Participation completed in the Health History Information (B) and Medical Certification (D). It requires an x-ray and diagnosis by a doctor. Athletes testing positive can not compete in Swimming Starts, Butterfly Stroke, Alpine Skiing and Soccer.
- Healthy Athletes Program Release form is now included on this Application for Participation.
- Please check appropriate box at top of Application for Participation– New Athlete or Renewal.

Important Reminders:

Parents/Guardians - keep a copy for yourself and give the original to your Program Coordinator

Program Coordinators –mail the original to the State office and keep a copy in the program files, make sure your coaches are carrying a copy in a confidential manner.

Coaches –carry a copy in a confidential manner with you at all times when you are with the athletes.

Special Olympics Vermont
Attention: Games Registration
368 Avenue D, Suite 30
Williston, Vermont 05495

* This form is good for 3 years. If a change in medical history occurs, please update the form.
* Print or Type all information & make sure your copies are legible.
* If this form isn't legible or complete – it will be returned to you.

SPECIAL OLYMPICS VERMONT APPLICATION FOR PARTICIPATION

This application expires three (3) years from date of exam.

→ Print Legibly or Type Information on Form & Make Sure Your Copy is Legible ←

Medical forms will not be accepted if incomplete, illegible or faxed.

SECTION A - ATHLETE INFORMATION

New Athlete ☐
Renewal ☐

Local Program: ______________________ **Social Security Number** _____ - _____ - _____

Athlete Name (First - Last): ______________________

Address: ______________________ City: ______________ State: ____ Zip: ________

PHONE: ______________________

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

Athlete Parent / Guardian ______________________

Emergency Contact Name ______________________ Phone ______________________

Health/Medical Insurance Co. ______________________ **Policy #** ______________________

SECTION B - HEALTH HISTORY INFORMATION

Check Yes or No	YES	NO
1 – Heart disease/defect/High blood pressure	☐	☐
2 – Chest pains	☐	☐
3 – Seizures/Epilepsy/Fainting spells	☐	☐
4 – Diabetes	☐	☐
5 – Concussion or serious head injury	☐	☐
6 – Atlantoaxial X-ray evaluation	☐	☐
7 – Blindness / visual problems	☐	☐
8 – Eyeglasses/Contacts	☐	☐
9 – Hearing impairment/Deafness	☐	☐
10 - Hearing Aid	☐	☐
11 – Recent contagious disease/hepatitis	☐	☐
12 – Bone or joint problems	☐	☐
13 – Heat stroke/Exhaustion	☐	☐
14 – Tobacco use	☐	☐
15 – Easy bleeding	☐	☐
16 – Emotional/psychiatric/behavioral	☐	☐

Check Yes or No	YES	NO
17 – Sickle cell disease/trait	☐	☐
18 – Immunizations up-to-date	☐	☐
19 – Date of last Tetanus ---------- / ---------- / ----------		
20 – Allergies	☐	☐
21 – To Medicines: List below if Yes	☐	☐
22 – To Food: List below if Yes	☐	☐
23 – To Insect bites/stings: List below if Yes	☐	☐
24 – **Down Syndrome** – yes/no	☐	☐
25 – X-ray done to check Instability?	☐	☐
26 – Was x-ray positive for Instability?	☐	☐
27- Date of x-ray _____/_____/________		

If no x-ray has been done or has tested positive – athlete can not compete in Swimming Starts, Butterfly Stroke, Alpine Skiing and Soccer
Note: Doctor must complete Down Syndrome Section of Medical (D)

Comments: ______________________

SECTION C – MEDICATIONS

Please indicate if there are no medications.

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

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 keep Section C - Medications - updated & accurate concerning changes in medication, amounts, times needed or any other medication information.

Name of person completing health information ______________________ **Date** __________

(OVER)

SECTION D – MEDICAL CERTIFICATION

NAME OF ATHLETE ___________________________________

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 in Swimming Starts, Butterfly Stoke, Alpine Skiing and/or Soccer. Please indicate if below

☐ **No Evidence of Altanto-axial Instability** ☐**Positive or equivocal evidence of Altanto-axial Instability**

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
Vision	☐	☐	Cardiovascular system	☐	☐	Cranial nerves	☐	☐
Hearing	☐	☐	Respiratory system	☐	☐	Coordination	☐	☐
Oral Cavity	☐	☐	Gastrointestinal system	☐	☐	Reflexes	☐	☐
Neck	☐	☐	Genitourinary system	☐	☐			
Extremities	☐	☐						

RESTRICTIONS: ___________________________________

Physicians NAME (PRINT) ______________________ **Phone** ______________

Physicians SIGNATURE ______________________ **Date** ______________

Physicians Address ___________________________________

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.

I understand that by signing below I consent to participate in the **Special Olympics Healthy Athletes Program** that provides individuals 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. I understand there is no obligation for me to participate in the **Healthy Athlete Program** and that I may decide not to participate. Provisions 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 these provisions, responsible for my health.

By signing below, I consent to the athlete's participation in the Healthy Athlete Program. 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 (if athlete is under 18)______________________ **Date** ______________

Address / City / Zip ___________________________________

Phones (W) ______________ **(H)** ______________ **(Cell)** ______________

Signature of Adult Athlete ______________________ **Date** ______________

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** ______________