



# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

Check If **NEW** Athlete (Never participated in Special Olympics before)

OFFICE USE ONLY	
Date Rec'd:	
Verified by:	

**SECTION A – ATHLETE INFORMATION** *Required once every three (3) years for all athletes.*  
*Please print clearly in blue or black ink.*

REGION/AREA/LOCAL PROGRAM: \_\_\_\_\_ YEAR STARTED IN SPECIAL OLYMPICS: \_\_\_\_\_

**ATHLETE INFORMATION**

ATHLETE NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (NICKNAME) \_\_\_\_\_

DATE OF BIRTH (month/day/year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

GENDER (circle): Male Female

ADDRESS: \_\_\_\_\_ (APT/STE) \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_ MOBILE PHONE: (\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_

HEALTH INSURANCE COMPANY: \_\_\_\_\_ POLICY #: \_\_\_\_\_

ETHNIC BACKGROUND: African Amer. →  Anglo →  Asian/Pacific Islands →  Hispanic →  Native Amer. →  Other not listed →  \_\_\_\_\_

**ATHLETE EMPLOYMENT INFORMATION**

EMPLOYER: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_

**PARENT/GUARDIAN INFORMATION**

PARENT/GUARDIAN NAME: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ MOBILE PHONE: (\_\_\_\_) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

EMAIL: \_\_\_\_\_

**PARENT/GUARDIAN EMPLOYMENT INFORMATION**

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_ Zip: \_\_\_\_

**EMERGENCY CONTACT INFORMATION**

CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_ MOBILE PHONE: (\_\_\_\_) \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_

**SECTION B – ATHLETE HEALTH INFORMATION** *Required once every three (3) years for all athletes.*  
 Please print clearly in blue or black ink.

**MEDICAL HISTORY**

IMPORTANT: Any significant change in the athlete's health or condition should be reviewed by a licensed examiner before further participation.

	Yes	No		Yes	No
1. Heart Disease/Heart Defect/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	14. Allergy to the following (be specific)	<input type="checkbox"/>	<input type="checkbox"/>
2. Chest Pain or Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Foods _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Insect Sting/Bite _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	15. Special Diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Have cervical spine (neck bone) x-rays been done	<input type="checkbox"/>	<input type="checkbox"/>	16. Exercise induced wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Atlanto Axial Instability	<input type="checkbox"/>	<input type="checkbox"/>	17. Tendency to bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
6. Parent/Sibling (under 40) died of heart disease	<input type="checkbox"/>	<input type="checkbox"/>	18. Emotional/psychiatric/behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Absence of one kidney or testicle	<input type="checkbox"/>	<input type="checkbox"/>	19. Serious bone or joint disorder	<input type="checkbox"/>	<input type="checkbox"/>
8. Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	20. Sickle cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>
9. Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	21. Hearing aid/hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
10. Heat stroke/exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	22. Contact lenses/eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>
11. Other problem that would interfere w/ sports participation	<input type="checkbox"/>	<input type="checkbox"/>	23. Dentures/false teeth	<input type="checkbox"/>	<input type="checkbox"/>
List _____			24. Immunizations (shots) are up-to-date	<input type="checkbox"/>	<input type="checkbox"/>
12. Impaired motor ability	<input type="checkbox"/>	<input type="checkbox"/>	25. Date of last tetanus shot	_____ / _____ / _____	
13. Uses a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>			

**ADDITIONAL COMMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS** Please print medication name, amount, date prescribed and number of times per day medication needs to be taken

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PERSON COMPLETING FORM** (normally parent/guardian or adult athlete) \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**IF HISTORY SIGNED BY ADULT ATHLETE** – I have reviewed the health history with the athlete whose signature appears above

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to athlete (family member, friends, coach) \_\_\_\_\_

**SECTION C - MEDICAL CERTIFICATION** *Required once every three (3) years for all athletes.*

MUST BE PERFORMED AND COMPLETED BY A LICENSED MEDICAL EXAMINER (PHYSICIAN, PHYSICIAN ASSISTANT, OR CHIROPRACTOR)

**EXAMINER'S NOTE:** If the athlete has Down Syndrome, Special Olympics requires 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. The sports and events for which such a radiological examination is required are: gymnastics, pentathlon, butterfly stroke in aquatics, diving start in aquatics, high jump, & soccer (football).

BRIEF EXAM: HT \_\_\_\_\_ WT: \_\_\_\_\_ PULSE: \_\_\_\_\_ B.P. \_\_\_\_\_ ENT: \_\_\_\_\_ HEART: \_\_\_\_\_ LUNGS: \_\_\_\_\_

I have reviewed the above health information and examined the athlete named in the application, and certify there is no medical reason available to me which would preclude the athlete's participation in Special Olympics.

RESTRICTIONS \_\_\_\_\_  
 Examiner's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Examiner's Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_