

APPLICATION FOR PARTICIPATION

Team/Program Affiliation:__

Western Washington – 1809 7th Ave, Suite 1509, Seattle, WA 98101-4400 Ph. 1.800.752.7559 or 206.362.4949 Fax 206.361.8158 Eastern Washington – PO Box 1640 Richland, WA 99352-6640 Ph. 1.800.442.2508 or 509.946.5921 Fax 509.396.9902

ATHLETE INFORMATION											
Athlete Name: Date of Birth: _/											
PARENT/GUARDIAN INFORMATION											
PARENT/GOARDIAN INFORMATION Name: Phone:() Phone#2:() E-mail: @ Address: City: State: Zip Code:											
HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER/PHYSICIAN											
*Heart disease/heart defect/high blood pressure Chest pain *Seizures/epilepsy/fainting spells *Diabetes *Concussion or serious head injury *Major surgery or serious illness Heat stroke/exhaustion *Blindness/visual problem Hearing impaired Deaf/complete hearing loss			□ □ Bone or joint problem □ □ *Asthma □ □ Tobacco Use □ □ Easy bleeding □ □ Emotional/psychiatric/behavioral If yes, explain: □ □ Sickle cell trait or disease □ □ Immunizations up to date Date of most recent □ (*) Ref			Foo Ins	Medicines: Food: Insect Stings/Bites: Special Diet				
MEDICATIONS Please print medication name, amount, date prescribed and number of times per day medication are given. Use separate sheet for additional space.											
Medication Name Docade		Date	Times	Medication Name		Dosage	Date Prescribed	Times Per Day			
SIGNATURE OF PAREN	NT/CAREGIVER/AD	ULT ATHLET	E:			> DA	TE:				
AT	LANTO-AXIAL II	ISTABILITY	ASSESSN	IENT FOR A	THLETES WIT	TH DOWN S	YNDROM	E			
Physician'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: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer). YES NO Has an x-ray evaluation for Atlanto-axial Instability been done? If yes, was it positive for Atlanto-axial Instability? (Positive indicates that the atlanto-dens interval is 5mm or more)											
PHYSICAL EXAMINATION											
Blood pressure:/		lbs. Height:									
NORMAL ABNORMAL NORMAL ABNORMAL Cardiovascular system Respiratory system Cardiovascular system Respiratory system Gastrointestinal system Respiratory system Gastrointestinal system Seritourinary system Skin				NORMAL ABNORMAL Cranial nerves Reflexes Other: Primary MR Etiology/Category (if known):							
I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics. RESTRICTIONS:											
► PHYSICIAN'S SIGNATURE: Print Physician's Name: ► DAT						DATE:					
Address:		City:		Sta	ate: Zip:	:	Phone:				

IMPORTANT: This form is not valid unless <u>signed by Physician on page 1 and Adult Athlete or Guardian on page 2</u>. FORM IS VALID FOR THREE (3) YEARS FROM DATE OF PHYSICAL EXAM.

	FORM IS VALID FOR THREE (3) YEARS FROM DATE OF PHYSICAL EXA	М.					
SE	CTION A: RELEASE TO BE COMPLETED BY ADULT ATHLETE						
I,	am at least 18 years old and have submitted the attached application f	or participation in Special Olympics.					
•	oresent 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 a licensed medical professional has reviewed the health information contained in my application and has certified, based on an independent medical examination, at there is no medical evidence that would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in rets or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have appleted the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction or I have had a full lological examination that establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with into-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian rts, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer). cial Olympics has my permission forever to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these poses and activities.						
•	I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program, which provide status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotio etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in grocommunicate the overall health needs of athletes and to develop programs to address those needs. I understand there is not healthy Athletes Program and that I may decide not to participate. Provision of these health services is not intended as a substant I should seek my own independent medical advice and assistance irrespective of the provisions of these services and the provision of these provisions responsible for my health. I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each excontact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific excontact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific excontact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific excontact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific excontact the Special Olympics activities, I should need emergency medical treatment, and I am not able to garrangements for the treatment for any reason, I authorize Special Olympics to take whatever measure it deems necessary including, if necessary, hospitalization. (IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, INITIAL IT AND SIGN AND ATTACH THE "SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT" FORM)	n areas (height, weight, sun protection, oup form (anonymously) to assess and o obligation for me to participate in the abstitute for regular care. I also understand nat Special Olympics is not through the ent may differ. I understand that I should went or the housing policy in general. give my consent or make my own to protect my health and well-being, PLEASE CROSS OUT THIS PARAGRAPH,					
	he Athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand the provisions of this release.	that by signing this paper, I am saying that I					
	Signature of Adult Athlete:	Date:					
	reby certify that I have reviewed this release with the Athlete whose signature appears above. I am satisfied based on that review	ew that the Athlete understands this release					
	has agreed to its terms. nt Name: Date: Relationship to Athlete:	_(e.g. family member, teacher, coach, etc.)					
	20002000						
<u>SE</u>	CTION B: RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE						
	n the parent/guardian of, the minor Athlete, on whose behalf I have substicipation in Special Olympics. The Athlete has my permission to participate in Special Olympics activities.	mitted the attached application for					
	I further represent and warrant that to the best of my knowledge and belief, the Athlete is physically and mentally able to p With my approval, a licensed medical professional has reviewed the health information set forth in the Athlete's application medical examination that there is no medical evidence, which would preclude the Athlete's participation. I understand that cannot participate in sports or events, which, by their nature, result in hyper-extension, radical flexion or direct pressure on physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Specia the Athlete has had a full radiological examination, which establishes the absence of Atlanto-axial Instability. I am aware the Release for Athletes with Atlanto-Axial Instability," form which establishes the absence of Atlanto-axial Instability, the Athlete before he/she can participate in judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in sw snowboarding, squat lift and football team competition (soccer). In permitting the Athlete to participate, I am specifically granting my permission, forever, to Special Olympics to use the Atheither television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, pronactivities of Special Olympics and/or applying for funds to support these purposes and activities. By signing below, I am also permitting the Athlete to participate in the Special Olympics Healthy Athletes Program, which preprotection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understan no obligation for the Athlete to participate in the Healthy Athletes Program and that I may decide that the Athlete will not professional decidency of the provisions of these services and that Special Olympics program in my jurisdiction if I	and has certified based on an independent to if the Athlete has Down Syndrome, he/she the neck or upper spine, unless I and two all Olympics Program in my jurisdiction, or at if I choose not to complete the "Special te must have the radiological examination imming, high jump, alpine skiing, allete's likeness, name, voice and words in moting or communicating the purposes and rovides individual screening assessments of commotion areas (height, weight, sun to used in group form (anonymously) to do that notwithstanding my consent, there is conticipate. I understand that the provision her own medical advice and assistance ing itself responsible for Athlete's health. The housing policy in general. In not personally present so as to be eccessary to ensure that the Athlete is to protect the Athlete's health and well-GRAPH, INITIAL IT AND SIGN AND ATTACH lease, and have explained these provisions to					
	Athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf						

Date:

Signature of Parent/Guardian: _