

MEDICAL & CONSENT RELEASE



For Participation in Special Olympics

REGION: _____

- Special Athlete
Special Partner

PART 1: (ATHLETE INFORMATION)

Training Club Name: _____
Athlete's Name: _____
Athlete's Address: _____ City: _____ State: _____ Zip: _____
Parent/Guardian: _____
Social Security #: XXX-XX-____
Emergency Contact (if other than parent/guardian): _____
Health/Accident Insurance Company: _____

PART 2: (HEALTH HISTORY)

Yes No To be completed by parent or guardian Yes No
* Heart Disease / Heart Defect / High Blood Pressure
* Chest Pain
* Seizures / Epilepsy / Fainting Spells
* Diabetes
* Concussion / Serious Head Injury
Heat Stroke / Exhaustion
* Blindness / Visual Problem
Contact Lenses / Glasses
Hearing Loss / Hearing Aid
Bone or Joint Problem
Allergy:
Medicines:
Insect Stings/Bites:
Special Diet
*Asthma
Tobacco Use
Easy Bleeding
Emotional / Psychiatric / Behavioral
Sickle Cell Trait or Disease
Immunizations up to date
Other: _____

Date of most recent tetanus immunization ____ / ____ / ____

Atlanto-Axial Instability Assessment for athletes with Down Syndrome (see back) Exam taken [] Y [] N Positive for [] Y [] N
Signature of parent / caregiver / adult athlete: _____ Date: _____

PART THREE: (PHYSICAL EXAMINATION)

Blood pressure: ____ / ____ Weight ____ Height ____
Normal Abnormal Normal Abnormal Normal Abnormal
[] Vision [] Cardiovascular system [] Neck
[] Hearing [] Respiratory system [] Coordination
[] Reflexes [] Skin [] Extremities

Other: _____ Primary MR Etiology / Category (if known): _____

I have reviewed the above health information and have performed an examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

EXAMINER'S SIGNATURE: _____ Date: _____
EXAMINER'S NAME: _____ MD License#: _____
ADDRESS: _____ PHONE#: _____

PART 4: (RELEASE STATEMENT)

INFORMED CONSENT PROVIDED BY:
Name: _____
Address: _____ City: _____ State: _____ Zip: _____ Home Phone #: _____

Relationship to Athlete: [] Self (adult athletes only) [] Parent [] Legal Guardian [] Adult Family Member [] Approved Agency Staff
OFFICIAL SPECIAL OLYMPICS NEW YORK RELEASE FORM TO BE COMPLETED BY ADULT ATHLETE & PARENT OR GUARDIAN

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics.
I AM THE PARENT/GUARDIAN OF _____, THE MINOR ATHLETE, on whose behalf I have submitted the attached application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

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 on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Chapter program in my state, or I have had a full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-Axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer. I understand that participation in the Healthy Athletes venues is voluntary and that authorization can be withdrawn at any time. I understand that the provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future. 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. 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 these 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 that 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 its terms.
Name (Print): _____ Relationship to athlete _____ (e.g. family member, teacher, coach, etc.)
Signature of Parent/Guardian: _____ Date: _____