

APPLICATION FOR PARTICIPATION SPECIAL OLYMPICS MICHIGAN AREA _____ LOCAL _____

**SECTION A
ATHLETE
PERSONAL
DATA**

Athlete first name and initial		Athlete last name		Email address		Athlete date of birth (mm/dd/yy) / /	
Home address (number and street)			Apt. no.	Phone number for athlete		Please indicate the athlete's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City or town, state, and zip code				Athlete's health / insurance company		Policy number	
Parent/guardian first name and initial		Parent/guardian last name		Name for an emergency contact			
Parent/guardian address (number and street) if different from above				Phone number for emergency contact			
City or town, state, and zip code				Please indicate the athlete's race/ethnicity (optional): <input type="checkbox"/> American Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Other _____			
Parent/guardian home phone		Parent/guardian work phone					

**SECTION B
ATHLETE
HEALTH
DATA**

Please check yes or no to the following health conditions:

	Yes	No	
1			Asthma or exercise-induced wheezing
2			Seizure / Epilepsy Indicate frequency _____
3			Diabetes Please indicate: <input type="checkbox"/> Type I <input type="checkbox"/> Type II
4			Down syndrome Have x-rays been taken to check for atlantoaxial instability (AI)? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of x-ray _____ Was AI present? <input type="checkbox"/> Yes <input type="checkbox"/> No
5			Concussion/Serious head injury Date of injury _____
6			Bed wetter
7			Shunt
8			Motor impairment requiring special equipment
9			Allergies (please check box and list specific allergy) <input type="checkbox"/> Medicines _____ <input type="checkbox"/> Foods _____ <input type="checkbox"/> Insect bites/stings _____ <input type="checkbox"/> Other _____
10			Immunizations are up to date Date of last tetanus shot _____
11			Tendency to bleed
12			Chest pain/ Fainting spell/ Heat stroke/ Exhaustion
13			Deformities (for example, curvature of back, one kidney, one testicle, etc.)
14			Heart disease/ Heart defect/ High blood pressure
15			Special diet
16			Blood-borne contagious infection carrier (for example, HIV, Hepatitis B)
17			Emotional/ Psychiatric/ Behavioral problems
18			Bone or joint disorder
19			Urination/bowel problem
20			Visual/hearing impairment or correction (for example, blind or wears glasses/contacts or hearing aids)
21			Dental concerns (for example, dentures, braces, chipped teeth, bridges)
22			Major surgery or serious illness
23			Other or new problems that would interfere with or modify sports participation (for example, wheelchair, other assistive devices)
24			Have you ever been convicted or charged with a criminal offense, neglect, abuse, or assault?

For any 'yes' responses to questions 12-24, please explain:

25 Please indicate intellectual disability diagnosis if known (condition or cause):

SECTION C GUARDIAN RELEASE

By submitting this form, I hereby request permission for the above-named applicant (hereafter referred to as "entrant") to participate in Special Olympics. I represent and warrant that the entrant is physically and mentally able to participate in Special Olympics, and I submit a subscribed medical certificate. I understand that it is the entrants responsibility to acquire, review and complete the Athlete Code of Conduct form for the safety and health of both the entrant and fellow athletes. I grant permission for Special Olympics to use the likeness, voice, and words of the entrant in TV, radio, newspapers, magazines, and other media for the purpose of communicating the mission and activities of Special Olympics and/or applying for funds to support the mission and activities of Special Olympics. I authorize Special Olympics to take such measures and arrange for such medical and hospital treatment as may be deemed advisable for the health and well-being of the entrant in the event that he/she becomes ill or injured at any Special Olympics activity and no responsible adult authorized to act on the entrant's behalf is immediately available to be consulted as to the appropriate medical care for the entrant. I understand that if housing is provided at events, entrants will be sharing rooms with other entrants or volunteers of the same gender.

This form is not valid without the dated signature of a Parent/Legal Guardian and a Medical Examiner or if altered in any way. This form is valid for three years from the medical exam date.

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by the provision of this release.

Signature of Parent/Legal Guardian	Date
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Note to entrant (or parent of entrant) with Down Syndrome: If a radiological exam certifies the presence of atlantoaxial instability, the entrant and two physicians must complete the "Special Release for Athletes with Atlantoaxial Instability" to participate in sports that may cause hyper-extension, radial flexion, or direct pressure on the neck or upper spine.

SECTION D MEDICAL CERTIFICATION To be completed by examiner

Skin	Head	Eyes	Ears
Nose	Mouth/Throat	Neck	Lungs
Heart	Abdomen	Extremities	Genital
Athlete height		Athlete weight	Blood pressure

List health concerns/conditions that Special Olympics should be aware of for this athlete:

Please read and check box:

I have examined the individual named in this application and reviewed the Athlete Health Data in Section B, and I certify that there is no medical evidence available to me which would preclude this athlete from participation in Special Olympics.

Signature of Examiner	Date
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Examiner's Name	Examiner's Title (M.D., D.O., C.N.P, P.A.)
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Address	Phone
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Note to examiner: If the athlete has Down Syndrome, Special Olympics requires that a full radiological exam be conducted which certifies the absence of atlantoaxial instability before the athlete may participate in sports or events which may result in hyperextension, radial flexion, or direct pressure on the neck or upper spine.

List medications being taken by athlete. If more than 3 medications, attach a separate sheet listing all medications:

Medication Name	Dosage	Time(s) Administered	Date Prescribed