

U.S. Athlete Registration Form

Special Olympics



Required for all athletes participating in Special Olympics.

Local Special Olympics Program: _____

Athlete Information - To be completed by the athlete or parent/guardian/caregiver.

First name: _____ Last name: _____ Middle name: _____

Date of birth (dd/mm/yyyy): ____/____/____ Gender: Female Male Prefer not to answer

Email: _____ Phone number: _____ Mobile Landline

Home address: _____

Optional - Check all that apply:	
Race / Ethnicity	<input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian American <input type="checkbox"/> Black / African American <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Middle Eastern / North African <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer
Language(s) Spoken by Athlete	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign Language (ASL) <input type="checkbox"/> Other (please list): _____

Parent/Guardian Information - Required if minor or otherwise has a legal guardian.

First Name: _____ Last Name: _____ Relationship to athlete: _____

Email: _____ Phone number: _____ Mobile Landline

Home address: _____

Emergency Contact Same as Parent/Guardian

First name: _____ Last name: _____ Phone number: _____ Mobile Landline

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

Associated Conditions - Mandatory

Associated Conditions	<input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Fetal Alcohol Syndrome <input type="checkbox"/> Marfan Syndrome <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fragile X Syndrome <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Please specify other known intellectual disability diagnoses:	

Assistive Devices and Accommodations - Do you use any of the following? Check all that apply:

Mobility	<input type="checkbox"/> Walker <input type="checkbox"/> Braces or crutches <input type="checkbox"/> Wheelchair <input type="checkbox"/> Removable orthotics <input type="checkbox"/> Prosthetics <input type="checkbox"/> None
Lifestyle Aids	<input type="checkbox"/> CPAP <input type="checkbox"/> Dentures <input type="checkbox"/> Glasses, contact lenses, or protective eyewear <input type="checkbox"/> None
Communications	<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Communication devices <input type="checkbox"/> Sign Language <input type="checkbox"/> None
Medical Devices	<input type="checkbox"/> Implantable cardioverter defibrillator (ICD) <input type="checkbox"/> Implantable device for seizure management <input type="checkbox"/> VP Shunt <input type="checkbox"/> Pacemaker <input type="checkbox"/> None

Do you have a specific dietary requirement?	<input type="radio"/> Yes <input type="radio"/> No	If yes, please specify:
Do you use other assistive devices?	<input type="radio"/> Yes <input type="radio"/> No	If yes, please specify:

General Health Questions

Do you have a heart condition?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have asthma?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have diabetes that requires you to take insulin?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a vision impairment?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a hearing impairment?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a bleeding disorder?	<input type="radio"/> Yes	<input type="radio"/> No
Has a doctor ever limited your participation in sports?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have epilepsy or any type of seizure disorder?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have sickle cell disease?	<input type="radio"/> Yes	<input type="radio"/> No

Have you ever had a concussion?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please specify if it is to any of the following: <input type="checkbox"/> Insect stings <input type="checkbox"/> Medication/drugs <input type="checkbox"/> Food <input type="checkbox"/> Latex <input type="checkbox"/> Other (please specify): _____

Medication and Treatment - Please list:

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

Yes No

If yes, please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: _____

Today's date (dd/mm/yyyy): ____/____/____

Is this form being completed by someone other than the athlete? Yes No

If yes, please select the relationship to athlete:

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

Special Olympics encourages all participants to get a yearly physical examination.

WAIVERS, RELEASES, AND POLICIES

Please read the following information and check boxes fully before signing.

I agree to the following:

- 1. Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.
- 2. Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.
- 3. Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
 - I have a religious or other objection to receiving medical treatment.
 - I do not consent to blood transfusions.(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
- 4. Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.
- 5. Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."
- 6. Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").

I agree and consent to Special Olympics:

- using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
- using my contact information for communicating with me about Special Olympics.
- sharing my personal information confidentially with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
- I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.

Privacy Policy. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY (For athlete with Down syndrome only)

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION

In consideration of being allowed to participate in any way in Special Olympics activities, the undersigned acknowledges, appreciates, and agrees that:

1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;
2. If I observe any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest Special Olympics representative immediately; and,
3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

Athlete Name: _____

ATHLETE SIGNATURE

(required for adult athlete with capacity to sign legal documents)

I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.

Athlete Signature: _____

Date (dd/mm/yyyy): ____/____/____

PARENT/GUARDIAN SIGNATURE

(required for athlete who is a minor or lacks capacity to sign legal documents)

I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.

Parent/Guardian Signature: _____

Date (dd/mm/yyyy): ____/____/____

Printed Name: _____

Relationship: _____

**EVALUATION AND RESEARCH
(Optional)**

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

- Yes No

Athlete Medical Form

Special Olympics



To be completed by a Licensed Medical Practitioner qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name: _____

Date of birth (dd/mm/yyyy): ____/____/____

Height (in/cm)	Weight (lb/kg)	Waist Circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood Pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Does the athlete present with any of the following?										
High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No	Coeliac Disease			<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown		
Kidney Disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	Osteoporosis			<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	
Anemia	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown	Non-verbal			<input type="radio"/> Yes	<input type="radio"/> No		

Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="radio"/> Yes	<input type="radio"/> No
Was the athlete born without or missing a kidney, an eye, a testicle, or any other organ?	<input type="radio"/> Yes	<input type="radio"/> No

Does the athlete have any past surgeries?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Did the athlete ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Did the athlete ever have any broken bones or dislocated joints?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Does the athlete have liver disease?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Does the athlete have lung disease?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Does the athlete have heart disease?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown

Medical		
Eyes, ears, nose, and throat: include pupils, hearing	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Heart: Include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Lungs	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Abdomen	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Skin: HSV, MRSA, or tinea corporis	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Neurological	<input type="radio"/> Normal	<input type="radio"/> Abnormal

Musculoskeletal					
Neck	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Hip and thigh	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Back	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Knee	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Shoulder and arm	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Lower leg and ankle	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Elbow and forearm	<input type="radio"/> Normal	<input type="radio"/> Abnormal	Foot and toes	<input type="radio"/> Normal	<input type="radio"/> Abnormal
Wrist, hand, and fingers	<input type="radio"/> Normal	<input type="radio"/> Abnormal			

Additional findings for any of the above conditions:

Medical Physical Examination - To be completed by practitioner only.

MEDICAL ELIGIBILITY FOR SPORT (TO BE COMPLETED BY PRACTITIONER ONLY)

Licensed Medical Practitioner: It is recommended that the practitioner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If further medical evaluation is warranted, the practitioner must refer the athlete to a specialist and reassess the results from this examination to determine eligibility for participation.

- Medically eligible for all sports or for sports listed: _____ without restriction.
- Medically eligible for all sports or for sports listed: _____
with recommendations for further evaluation or treatment of: _____
- Not medically eligible pending further evaluation of: _____
- Not medically eligible to participate in the following sports: _____
- Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of licensed medical practitioner (print or type): _____ Date (dd/mm/yyyy): ___/___/___
Address: _____ Phone: _____
Signature of licensed medical practitioner: _____
NPI or License number: _____ License type (MD, DO, NP, or PA): _____