

Application for Participation

SECTION A - ATHLETE HEALTH INFORMATION

SOTN 8-20-2003

PROGRAM: _____

Athlete Social Security Number _____ - _____ - _____

Sex/Gender _____

Athlete Name _____

Date of Birth (month, day, year) ____/____/____

Address _____

Home Phone (_____) _____ - _____

Parent/Guardian Name _____

Home Phone (_____) _____ - _____

Address (If different from athlete.) _____

Work Phone (_____) _____ - _____

Email Address _____

Emergency Contact (If other than parent/guardian.) _____

Home Phone (_____) _____ - _____

Cell Phone (_____) _____ - _____

Health/Accident Company _____

Policy # _____

- | | | | |
|--|--------------|---|--------------|
| 1. Heart Disease/Heart Defect/High Blood Pressure | Yes___ No___ | 13. Impaired motor ability | Yes___ No___ |
| 2. Chest Pain or Fainting Spells | Yes___ No___ | 14. Uses a wheelchair | Yes___ No___ |
| 3. Seizure/Epilepsy | Yes___ No___ | 15. Allergy to the following (list specific) | Yes___ No___ |
| 4. Diabetes | Yes___ No___ | Medicine_____ | |
| 5. Down Syndrome | Yes___ No___ | Food_____ | |
| Have cervical spine(neck bone) X-rays been done | Yes___ No___ | Insect Sting/Bite_____ | |
| Presence of Atlanto Axial Instability | Yes___ No___ | | |
| 6. Parent/Sibling (under 40) died of heart disease | Yes___ No___ | 16. Special diet | Yes___ No___ |
| 7. Absence of vision/blind in one eye | Yes___ No___ | 17. Exercise induced wheezing | Yes___ No___ |
| 8. Absence of one kidney or testicle | Yes___ No___ | 18. Tendency to bleed easily | Yes___ No___ |
| 9. Concussion of serious head injury | Yes___ No___ | 19. Emotional/psychiatric/behavioral problems | Yes___ No___ |
| 10. Major surgery or serious illness | Yes___ No___ | 20. Serious bone of joint disorder | Yes___ No___ |
| 11. Heat stroke/exhaustion | Yes___ No___ | 21. Sickle cell trait or disease | Yes___ No___ |
| 12. Other problem that would interfere with sports participation...List_____ | Yes___ No___ | 22. Hearing aid/hearing loss | Yes___ No___ |
| | | 23. Contact lenses/eye glasses | Yes___ No___ |
| | | 24. Dentures/ false teeth | Yes___ No___ |
| | | 25. Immunizations (shots) are up-to-date | Yes___ No___ |
| | | 26. Date of last tetanus shot: ____/____/____ | |

A physical examination must be performed by a physician or a licensed examiner/nurse practitioner working under the supervision of a physician.

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 _____

IMPORTANT: If there is any significant change in the athlete's health, the athlete's condition should be reviewed by a licensed examiner before further participation.

SECTION B - MEDICAL CERTIFICATION

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 a radiological examination is required are: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football team competition (soccer).

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

RESTRICTIONS _____

EXAMINER'S SIGNATURE _____ DATE _____

EXAMINER'S NAME _____

ADDRESS _____

CITY _____ TN _____ ZIP _____ PHONE (_____) _____ - _____