

# SPECIAL OLYMPICS OKLAHOMA APPLICATION FOR PARTICIPATION

Application valid September 1, 2010 through August 31, 2013

Print or Type Information on Form & Fill-in Completely

## SECTION A - ATHLETE INFORMATION

Athlete Name (First - Last)

Date of Birth (mmddyyyy)        Male       Female

African American     Caucasian     Hispanic     Native American     Asian     Other

Area Name & City

2010 -'11 - Coach / Team       Phone (no hyphens)

2011 -'12 - Coach / Team       Phone (no hyphens)

2012 -'13 - Coach / Team       Phone (no hyphens)

Athlete's Parent/Guardian       Phone (no hyphens)

Emergency Contact Name       Phone (no hyphens)

Health/Medical Insurance Co.       Policy #

## SECTION B - HEALTH HISTORY INFORMATION (Check Yes or No)

1 – Heart disease/defect/High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	14 – Heat stroke/Exhaustion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2 – Chest pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15 – Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3 – Seizures/Epilepsy/Fainting spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16 – Easy bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4 – Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	17 – Emotional/psychiatric/behavioral	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5 – Concussion or serious head injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18 – Sickle cell disease/trait	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6 – Asthma / Breathing Difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19 – Immunizations up-to-date	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7 – Blindness / visual problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20 – Allergy: <input style="width: 120px; height: 15px;" type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8 – Eyeglasses/Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	21 – To Medicines: List below if Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9 – Hearing impairment/Deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	22 – To Food: List below if Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10 - Hearing Aid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23 – To Insect bites/stings: List below if Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11 – Recent contagious disease/hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24 – Down Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12 – Bone or joint problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	25 – X-ray done to check Instability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13 – Date of last Tetanus <input style="width: 120px; height: 15px;" type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26 – Was x-ray positive for Instability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Comments (150 characters)

## SECTION C - MEDICATIONS    List medications & dosages the Athlete is currently taking: Please fill in blanks & KEEP UPDATED

Medication Name	<input style="width: 230px; height: 25px;" type="text"/>	Dosage	<input style="width: 90px; height: 25px;" type="text"/>	Prescrip.Date	<input style="width: 120px; height: 25px;" type="text"/>	Times Per Day	<input style="width: 60px; height: 25px;" type="text"/>
Medication Name	<input style="width: 230px; height: 25px;" type="text"/>	Dosage	<input style="width: 90px; height: 25px;" type="text"/>	Prescrip.Date	<input style="width: 120px; height: 25px;" type="text"/>	Times Per Day	<input style="width: 60px; height: 25px;" type="text"/>
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**ALLERGIES TO MEDICATIONS - FOODS - INSECT BITES OR STINGS (150 characters)**

**NOTE TO PARENTS/GUARDIANS: It is the responsibility of the Parent/Guardian to complete & keep Sections B & C updated & accurate concerning changes in health status and all medication information.**

# SECTION D – MEDICAL CERTIFICATION

Athlete Name (First - Last)  Date

**NOTE TO PHYSICIAN:** If the athlete has Down Syndrome, Special Olympics requires that the athlete have a full radiological exam establishing the presence or absence of Atlantoaxial Instability before he/she may participate.

**Check Box** / I have reviewed the health information on & examined the athlete named in the application & certify that the athlete can participate in Special Olympics. Down Syndrome & other athletes' caregivers have been advised of any medical restrictions.

Blood Pressure	<input style="width: 100%;" type="text"/>	Pulse	<input style="width: 100%;" type="text"/>	Weight	<input style="width: 100%;" type="text"/>	Height	<input style="width: 100%;" type="text"/>
	Normal    Abnormal		Normal    Abnormal		Normal    Abnormal		Normal    Abnormal
Vision	<input type="checkbox"/> <input type="checkbox"/>	Cardiovascular system	<input type="checkbox"/> <input type="checkbox"/>	Cranial nerves	<input type="checkbox"/> <input type="checkbox"/>	Hearing	<input type="checkbox"/> <input type="checkbox"/>
Oral Cavity	<input type="checkbox"/> <input type="checkbox"/>	Respiratory system	<input type="checkbox"/> <input type="checkbox"/>	Coordination	<input type="checkbox"/> <input type="checkbox"/>	Neck	<input type="checkbox"/> <input type="checkbox"/>
		Gastrointestinal system	<input type="checkbox"/> <input type="checkbox"/>	Reflexes	<input type="checkbox"/> <input type="checkbox"/>		
		Genitourinary system	<input type="checkbox"/> <input type="checkbox"/>	Extremities	<input type="checkbox"/> <input type="checkbox"/>		

**RESTRICTIONS:**

**\* SOOK physicals may be done & signed by Physicians, Physician Assts., Nurse Practitioners or Clinical Nurse Specialists.**

<b>MEDIC'S NAME (PRINT)</b>	<input style="width: 100%;" type="text"/>	Phone	<input style="width: 100%;" type="text"/>
<b>MEDIC'S SIGNATURE</b>	<input style="width: 100%;" type="text"/>	Date	<input style="width: 100%;" type="text"/>
<b>PRIMARY CARE DOCTOR</b>	<input style="width: 250px;" type="text"/>	CITY	<input style="width: 150px;" type="text"/>
		PHONE	<input style="width: 150px;" type="text"/>

**This form must have an approved medical signature in Section D to be valid.**

## OFFICIAL SPECIAL OLYMPICS RELEASE FORM

**RELEASE MUST BE COMPLETED BY PARENT/GUARDIAN OR 18 YR. OLD ADULT ATHLETE ACTING AS OWN LEGAL GUARDIAN**

**I, the Parent/Guardian OR the 18 yr. old Adult Athlete** submit this Application for Participation in Special Olympics.

I represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in this application and has certified, based on a medical examination, that there is no medical evident which would preclude the athlete from participating in Special Olympics. I understand that if the athlete has Down Syndrome, the athlete cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine unless the athlete and physician have completed the official "Down Addendum Form", available from the Special Olympics State office. I am aware that the x-ray exam is required before any athlete with Down Syndrome may participate in Special Olympics, especially in the following: equestrian, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

Special Olympics has my permission, both during and anytime after, to use the athlete's 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 those purposes and activities.

If, during the athlete's participation in Special Olympics activities, the athlete should need emergency medical treatment, and I (the parent/guardian or adult athlete) am not able to give consent or make arrangements for that treatment, I authorize Special Olympics to take whatever measures necessary to protect the athlete's health and well-being, including, if necessary, hospitalization.

By signing below, I consent to the athlete's participation in the Healthy Athlete Program. I understand that I should seek independent medical advice and assistance as I am responsible for the athlete's health. I understand that information gathered as part of the screening process may be used anonymously to assess and communicate overall health and needs of athletes and to develop programs to address those needs.

**I, the adult athlete,** 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.

**I, the parent/guardian of this athlete,** hereby give my permission for this athlete to participate in Special Olympics games, training, recreation programs, physical activity programs and Healthy Athletes program. By signing, I am saying that I agree to the provisions of this release.

<b>Signature of Parent/Guardian</b>	<input style="width: 100%;" type="text"/>	<b>Date</b>	<input style="width: 100%;" type="text"/>
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<b>Address</b>	<input style="width: 100%;" type="text"/>	<b>City</b>	<input style="width: 100%;" type="text"/>	<b>Zip</b>	<input style="width: 100%;" type="text"/>
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<b>Phones (W)</b> ( no hyphens)	<input style="width: 100%;" type="text"/>	<b>(H)</b> ( no hyphens)	<input style="width: 100%;" type="text"/>	<b>(Cell)</b> ( no hyphens)	<input style="width: 100%;" type="text"/>
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<b>Signature of Adult Athlete</b>	<input style="width: 100%;" type="text"/>	<b>Phone</b> ( no hyphens)	<input style="width: 100%;" type="text"/>
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<b>Address</b>	<input style="width: 100%;" type="text"/>	<b>City</b>	<input style="width: 100%;" type="text"/>	<b>Zip</b>	<input style="width: 100%;" type="text"/>
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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.

<b>Name (print)</b>	<input style="width: 100%;" type="text"/>	<b>Relationship</b>	<input style="width: 100%;" type="text"/>
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**Keep the original medical form. Submit only copies of the original with entry forms.**