

Circle One

NEW RENEWAL

APPLICATION FOR PARTICIPATION (Medical Form)

(must be completed and signed by licensed examiner every 3 years)



COUNTY: _____

School/Agency: _____

SSN: _____ / _____ / _____

T-shirt Size: _____ Children: _____ OR Adult: _____

LAST NAME _____ FIRST _____

SEX M or F

DATE OF BIRTH month/day/year

Street Number/Address _____

City _____ State _____ Zip Code _____

Email _____

Parent/Guardian _____

Home Phone (_____) _____

Address (if different) _____

Work Phone (_____) _____

City _____ State _____ Zip Code _____

Emergency Contact (other than parent/guardian) _____

Emerg. Phone (_____) _____

Health Insurance Company _____

Ins. Policy # _____

Signature of parent/guardian/adult athlete completing form _____

FOR ATHLETES WITH DOWN SYNDROME -- Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

- Has an x-ray evaluation for atlantoaxial instability been done?
If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

IS THERE PRESENT OR A HISTORY OF (to be completed by parent/caregiver):

- Heart problems/high blood pressure, Chest pain, Seizures/epilepsy/fainting spells, Diabetes, Hearing aid/hearing problems, Blindness/vision problem, Absence of one kidney or testicle, Tobacco use, Major surgery or serious illness, Heat stroke/exhaustion, Easy bleeding, Bone/joint problems, Sickle cell disease or trait, Uses a wheelchair, Emotional/psychiatric/behavioral problems, Asthma/breathing problems with exertion, Contact lenses/glasses/dentures/false teeth, Head injury/history of concussion, Immunizations (shots) are up-to-date, Special Diet Needs (list below), Year of last tetanus shot

Other problems that would interfere with participation _____

Allergy to the following (list specific):

Food _____ Insect sting/bites _____

Medication _____

MEDICATIONS

Table with 8 columns: Medication Name, Dosage, Date Presc., Times per day, Medication Name, Dosage, Date Presc., Times per day

PHYSICAL EXAMINATION

Table with 10 columns: Blood Pressure, Pulse, Weight, Height, Vision, Hearing, Neck, Skin, Oral Cavity, Extremities, Coordination, Reflexes, Cardiovascular system, Respiratory system, Gastrointestinal system, Genitourinary system, Cranial nerves

Other: _____

Primary MR Etiology/Category _____

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

Restrictions _____

Examiner's Name: _____ Certification: MD DO DC PA ARNP

EXAMINER'S SIGNATURE _____ DATE: _____

OPTIONAL INFORMATION

Ethnic background: Asian African American Caucasian Hispanic Native American Other