Athlete ID or Social Security #	APPLICATION FOR ATHLETE PARTICIPATION IN SPECIAL OLYMPICS	Please check appropriate box:
Male _____ Female_____		☐ Special Olympics Athlete
Date of Birth_____/_____/_____		☐ Unified Teammate / Partner
Height_____Weight_____	COUNTY School or Agency	

Name of Athlete:	Day Phone Number: ( )	Evening Phone Number: ( )	
Address:	City:	State:	Zip:
Parent or Guardian:	Day Phone Number: ( )	Evening Phone Number: ( )	
Address:	City:	State:	Zip:

EMERGENCY INFORMATION

Emergency Contact Person:	Day Phone Number: ( )	Evening Phone Number: ( )	
Address:	City:	State:	Zip:

HEALTH AND ACCIDENT INSURANCE INFORMATION

Company Name:
(Athletes without insurance, write NONE) Policy Number:

HEALTH INFORMATION

Please Circle Appropriate:

Down Syndrome	YES	NO	Fainting Spells	YES	NO
Atlanto-axial instability Evaluation by X-ray	YES	NO	Heat illness or Cold injury	YES	NO
(circle YES for positive, NO for negative			Hernia or Absence of 1 Testicle	YES	NO
and NONE for no X-Ray available)	NONE		Recent Contagious Disease or Hepatitis	YES	NO
HISTORY OF			Kidney problems or loss of function in one kidney	YES	NO
Diabetes	YES	NO	Pregnancy	YES	NO
Heart Problems	YES	NO	Bone or Joint problems	YES	NO
Seizures	YES	NO	Contact Lens / Glasses	YES	NO
Legally Blind	YES	NO	Dentures / False Teeth	YES	NO
Vision problems and/or less than 20/20			Emotional problems	YES	NO
vision in one or both eyes	YES	NO	Special Diet needs	YES	NO
Legally Deaf	YES	NO	Asthma	YES	NO
Hearing Aid / Hearing problems	YES	NO	High / Low Blood Pressure	YES	NO
Requires Wheelchair	YES	NO	Other		
Motor impairment requiring special equipment	YES	NO			
Non-Verbal Individual	YES	NO	Blood Pressure: _____/_____	Pulse:_____	
Bleeding Problem	YES	NO	COMMENTS - SEE BACK		

MEDICATIONS

Medication Name:	Amount:	Time:	Date Prescribed:

Allergies to Medication:

IMMUNIZATIONS

Tetanus: Yes No Date of Last Tetanus Shot: Polio: Yes No

Signature of Person Who Completed Health Information (Normally signed by Parent, Guardian or Adult Athlete)

SIGNATURE: DATE:

IF THERE IS ANY SIGNIFICANT CHANGE IN THE ATHLETE'S HEALTH, THE ATHLETE'S CONDITION SHOULD BE REVIEWED BY A PHYSICIAN BEFORE FURTHER PARTICIPATION

MEDICAL CERTIFICATION

NOTICE TO PHYSICIAN: If the athlete has Down Syndrome, Special Olympics requires that the athlete have 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 hyper-extension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

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

THIS CERTIFICATON IS VALID UP TO 3 YEARS

Athlete Restrictions:			
Physician's Name:		Phone Number ( )	
Address:	City:	State:	Zip:
PHYSICIAN'S SIGNATURE:		DATE:	

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MUST BE SIGNED BY MD, DO, CRNP, FNP or PA