



ATHLETE RELEASE FORM

Section A.

RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical professional has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence that would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction, or I have had a full radiological examination that establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer).

Special Olympics has my permission forever to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand there is no obligation for me to participate in the Healthy Athletes Program and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment for any reason, I authorize Special Olympics to take whatever measures it deems necessary to protect my health and well-being, including, if necessary, hospitalization. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT FORM)**

I, the Athlete named above, 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.

Signature of Adult Athlete: _____ Date: _____

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.

Print Name: _____ Date: _____

Relationship to Athlete: _____ (e.g. family member, teacher, coach, etc.)

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS CONNECTICUT

LOCAL PROGRAM: _____ PLEASE CHECK NEW RENEWAL

Name (First – Last): _____

Date of birth: ____/____/____ Gender Male Female Phone: () _____

Street: _____

City: _____ State: _____ ZIP Code: _____

PARENT OR GUARDIAN INFORMATION

Name _____

Address (if different than athlete's) _____

City _____ State: _____ ZIP Code: _____

Phone Home: _____ Work: _____ Mobile: _____

E-Mail _____

EMERGENCY CONTACT IF DIFFERENT THAN PARENT OR GUARDIAN

Name: _____ Phone: _____

HEALTH HISTORY

AN UP TO DATE HEALTH HISTORY AND A PHYSICAL EXAMINATION PERFORMED BY A LICENSED PHYSICIAN IS REQUIRED UPON ENTRY INTO THE PROGRAM. A PHYSICAL EXAMINATION IS REQUIRED EVERY 3 YEARS FOR ATHLETES WITH "YES" RESPONSES TO ITEMS 1 -5. A PHYSICAL EXAMINATION IS REQUIRED FOR ALL ATHLETES WITH A "NEW PROBLEM" RESPONSE TO ITEMS 7-11. ATHLETES MUST SUBMIT THIS FORM EVERY 3 YEARS WHETHER OR NOT AN EXAMINATION IS NECESSARY.

1. HEART PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	9. SURGERY OR ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	17. EMOTIONAL/BEHAVIOR PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO
2. CHEST PAINS <input type="checkbox"/> YES <input type="checkbox"/> NO	10. HEAT STROKE/COLD ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	18. BONE OR JOINT DISORDER <input type="checkbox"/> YES <input type="checkbox"/> NO
3. SEIZURES/EPILEPSY <input type="checkbox"/> YES <input type="checkbox"/> NO	11. OTHER PROBLEM (S) THAT WOULD INTERFERE	19. SICKLE CELL/TRAIT DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO
4. DIABETES <input type="checkbox"/> YES <input type="checkbox"/> NO	WITH SPORTS PARTICIPATION <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	20. HEARING LOSS/ HEARING AID <input type="checkbox"/> YES <input type="checkbox"/> NO
5. DOWN SYNDROME <input type="checkbox"/> YES <input type="checkbox"/> NO	LIST: _____	21. CONTACTS/EYEGLASSES <input type="checkbox"/> YES <input type="checkbox"/> NO
NECK X-RAY DONE <input type="checkbox"/> YES <input type="checkbox"/> NO	12. IMPAIRED MOBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	22. DENTURES/FALSE TEETH <input type="checkbox"/> YES <input type="checkbox"/> NO
INSTABILITY PRESENT <input type="checkbox"/> YES <input type="checkbox"/> NO	13. USES A WHEELCHAIR <input type="checkbox"/> YES <input type="checkbox"/> NO	23. DATE OF LAST TETANUS SHOT ____/____/____
6. BLINDNESS/VISION PROBLEM <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	14. SPECIAL DIET <input type="checkbox"/> YES <input type="checkbox"/> NO	24. LIST ALLERGY TO: INSECT STING <input type="checkbox"/> YES <input type="checkbox"/> NO
7. ABSENCE OF KIDNEY/TESTICLE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	15. ASTHMA <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICINE _____ <input type="checkbox"/> YES <input type="checkbox"/> NO
8. HEAD INJURY/CONCUSSION <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	16. BLEEDING PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	FOODS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO

ADDITIONAL COMMENTS: _____

MEDICATIONS: PLEASE PRINT MEDICATION NAME, AMOUNT AND NUMBER OF TIMES PER DAY MEDICATION NEEDS TO BE TAKEN: _____

SIGNATURES

EXAMINERS NOTE: If an 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 such 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).

RESTRICTIONS: _____ DATE: ____/____/____

EXAMINERS SIGNATURE: _____ DATE: ____/____/____

EXAMINERS NAME: _____ PHONE: () _____

APPLICANT OR PARENT/GUARDIAN SIGNATURE: _____ DATE: ____/____/____

THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED AND DATED TO BE CONSIDERED VALID.