Special Olympics
Michigan

SPECIAL OLYMPICS

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS
LEGAL GUARDIAN RELEASE

AREA # ____________

____
School or Facility

____
Area Reviewing Authority

PLEASE USE BALLPOINT PEN WHEN COMPLETING THIS FORM

Applicant's Name (Please Print) ______________________________
Last First Middle Initial Date of Birth

Address of Applicant ______________________________
Street City State ZIP Code

Applicant's Phone Number ____________ Applicant's Social Security Number ____________

☐ Male ☐ Female Is the applicant a wheelchair athlete? ☐ Yes ☐ No

I, the undersigned legal guardian of the above-named applicant (hereinafter referred to as the "Entrant"), hereby request permission for the Entrant to participate in the Special Olympics program.

I represent and warrant to you that the Entrant is physically and mentally able to participate in Special Olympics, and I submit herewith a health history as well as give my permission for a physical examination of the Entrant.

On behalf of the Entrant and myself, I acknowledge that the Entrant will be using facilities at his/her own risk and I, on my own behalf, hereby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to property of myself and Entrant.

In permitting the Entrant to participate, I am specifically granting permission to Special Olympics to use the likeness, voice and words of the Entrant in television, radio, films, newspapers, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purposes and activities of Special Olympics and appealing for funds to support such activities.

If I am not personally present at Special Olympics activities in which the Entrant is to compete, so as to be consulted in case of necessity, you are authorized on my behalf and at my account to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the Entrant.

I understand that the evaluating medical personnel are not necessarily performing a complete physical exam when filling out the Health Appraisal, which, along with this form, will allow the Entrant to be a participant in Special Olympics.

I understand that if the athlete has Down syndrome, he/she 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 a full radiological examination establishes the absence of Atlantoaxial Instability. I am aware that the sports and events for which this radiological examination is required are: gymnastics, diving, equestrian sports, pentathlon, butterfly stroke and diving starts in swimming, high jump, Alpine skiing, soccer and squat event (powerlifting).

Entrant Immunizations (Please check) ☐ Oral Polio ☐ Measles ☐ Tetanus Toxoid ☐ Date of Tetanus ____________

Emergency Contacts: (Please Print)

Name ____________

Day Phone ( ) ____________

Evening Phone ( ) ____________

Name of Medical Insurance Company ____________

Medical Insurance Policy Number ____________

Social Security Number of Policy Holder ____________

Please print Legal Guardian's Name ____________

Phone Number ____________

____
Legal Guardian Signature Date

THIS FORM NOT VALID WITHOUT SIGNATURE AND DATE — VALID AS LONG AS GUARDIAN'S SIGNATURE IS LEGAL. Rev. 11/92

SECTION A ATHLETE PERSONAL DATA

Athlete first name and initial	Athlete last name	Athlete social security number	Athlete date of birth (mm/dd/yy) / /
Home address (number and street)	Apt. no.	Phone number for athlete	Please indicate the athlete's gender: Male Female
City or town, state, and zip code		Athlete's health / insurance company	Policy number
Parent/guardian first name and initial	Parent/guardian last name	Name for an emergency contact	
Parent/guardian address (number and street) if different from above		Phone number for emergency contact	
City or town, state, and zip code		Please indicate the athlete's race/ethnicity (optional): American Indian, Asian, White, Black or African American, Hispanic or Latino, Other ______	
Parent/guardian home phone	Parent/guardian work phone		

SECTION B ATHLETE HEALTH DATA

Please check yes or no to the following health conditions:

#	Yes	No	Condition
1			Asthma or exercise-induced wheezing
2			Seizure / Epilepsy Indicate frequency ______
3			Diabetes Please indicate: Type I Type II
4			Down syndrome Have x-rays been taken to check for atlantoaxial instability (AI)? Yes No — Date of x-ray Was AI present? Yes No
5			Concussion/Serious head injury Date of injury ______
6			Bed wetter
7			Shunt
8			Motor impairment requiring special equipment
9			Allergies (please check box and list specific allergy) Medicines ______ Foods ______ Insect bites/stings ______ Other ______
10			Immunizations are up to date Date of last tetanus shot ______
11			Tendency to bleed
12			Chest pain/ Fainting spell/ Heat stroke/ Exhaustion
13			Deformities (for example, curvature of back, one kidney, one testicle, etc.)
14			Heart disease/ Heart defect/ High blood pressure
15			Special diet
16			Blood-borne contagious infection carrier (for example, HIV, Hepatitis B)
17			Emotional/ Psychiatric/ Behavioral problems
18			Bone or joint disorder
19			Urination/bowel problem
20			Visual impairment or correction (for example, blind or wears glasses/contacts)
21			Hearing impairment or correction
22			Dental concerns (for example, dentures, braces, chipped teeth, bridges)
23			Major surgery or serious illness
24			Other or new problems that would interfere with or modify sports participation (for example, wheelchair, other assistive devices)

For any 'yes' responses to questions 12-24, please explain:

25 Please indicate mental retardation diagnosis if known (condition or cause):

SECTION C GUARDIAN RELEASE

By submitting this form, I hereby request permission for the above-named applicant (hereafter referred to as "entrant") to participate in Special Olympics. I represent and warrant that the entrant is physically and mentally able to participate in Special Olympics, and I submit a subscribed medical certificate.

I grant permission for Special Olympics to use the likeness, voice, and words of the entrant in TV, radio, newspapers, magazines, and other media for the purpose of communicating the mission and activities of Special Olympics and/or applying for funds to support the mission and activities of Special Olympics.

I authorize Special Olympics to take such measures and arrange for such medical and hospital treatment as may be deemed advisable for the health and well-being of the entrant in the event that he/she becomes ill or injured at any Special Olympics activity and no responsible adult authorized to act on the entrant's behalf is immediately available to be consulted as to the appropriate medical case for the entrant.

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by the provision of this release.

Signature of Parent/Legal Guardian	Date

Note to entrant (or parent of entrant) with Down Syndrome: If a radiological exam certifies the presence of atlantoaxial instability, the entrant and two physicians must complete the "Special Release for Athletes with Atlantoaxial Instability" to participate in sports that may cause hyper-extension, radial flexion, or direct pressure on the neck or upper spine.

SECTION D MEDICAL CERTIFICATION To be completed by examiner

Skin	Head	Eyes	Ears
Nose	Mouth/Throat	Neck	Lungs
Heart	Abdomen	Extremities	Genital

Athlete height	Athlete weight	Blood pressure

List health concerns/conditions that Special Olympics should be aware of for this athlete:

Date of Athlete's Exam

Please read and check box:

☐ I have examined the individual named in this application and reviewed the Athlete Health Data in Section B, and I certify that there is no medical evidence available to me which would preclude this athlete from participation in Special Olympics.

Signature of Examiner	Date
Examiner's Name	Examiner's Title (M.D., D.O., C.N.P, P.A.)
Address	Phone

Note to examiner: If the athlete has Down Syndrome, Special Olympics requires that a full radiological exam be conducted which certifies the absence of atlantoaxial instability before the athlete may participate in sports or events which may result in hyperextension, radial flexion, or direct pressure on the neck or upper spine.

SECTION E MEDICATIONS

List medications being taken by athlete. If more than 3 medications, attach a separate sheet listing all medications:

Medication Name	Dosage	Time(s) Administered	Date Prescribed

This form is not valid without the dated signatures of a Parent/Legal Guardian and a Medical Examiner. This form is valid for three years from the medical exam date.