



DEMOGRAPHICS

Local Program Name _____

Athlete Information:

Name _____

Gender: Male__ Female__ Date of Birth ____/____/____

Employer (optional) _____

Home Phone _____ Work Phone _____

E-Mail Address _____

Street Address _____

City _____ State _____ ZIP _____

Parent/Guardian Information:

Name _____

Employer (optional) _____

Home Phone _____ Work Phone _____

Street Address _____

City _____ State _____ ZIP _____

E-Mail Address _____

Ethnicity (Optional) White__ Black/African American__ Asian__ Hispanic/Latino__ Other__

HEALTH INSURANCE & EMERGENCY CONTACT INFORMATION

Person to be contacted in case of emergency _____ Phone Number _____

Medical Insurance Company _____ Policy Number _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

- | | | | |
|--------------------------|---|--------------------------|--|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Disease/heart defect/high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> Allergy: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> Medicines: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Seizures/epilepsy/fainting spells | <input type="checkbox"/> | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Insect stings/bites _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Concussion or serious head injury | <input type="checkbox"/> | <input type="checkbox"/> Wheelchair/cane/walker (circle one) |
| <input type="checkbox"/> | <input type="checkbox"/> Major Surgery or serious illness | <input type="checkbox"/> | <input type="checkbox"/> Easy Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> Heat Stroke/exhaustion | <input type="checkbox"/> | <input type="checkbox"/> Emotional/psychiatric/behavioral |
| <input type="checkbox"/> | <input type="checkbox"/> Blindness/visual problem | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell trait of disease |
| <input type="checkbox"/> | <input type="checkbox"/> Contact lenses/glasses | <input type="checkbox"/> | <input type="checkbox"/> Immunizations up to date |
| <input type="checkbox"/> | <input type="checkbox"/> Hearing Loss/hearing Aid/non-Verbal | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Bone or joint problem | | _____ |
| | Date of most recent tetanus immunization ____/____/____ | | _____ |

Medications:

Please print medication name, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Prescribed	Times Per Day	Medication Name	Dosage	Date Prescribed	Times Per Day



ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: If the athlete has Down Syndrome, Special Olympics Colorado 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: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and soccer team competition.

- Yes No
- Has an x-ray evaluation for Atlanto-axial instability been done?
- If yes, was it positive for Atlanto-axial instability? (positive indicates that the Atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION - TO BE COMPLETED BY A LICENSED PHYSICIAN

Blood pressure: _____/_____/_____ Weight: _____ Height: _____

Normal/Abnormal

- Vision
 Hearing
 Oral cavity
 Neck
 Extremities

Normal/Abnormal

- Cardiovascular system
 Respiratory system
 Gastrointestinal system
 Genitourinary system
 Skin

Normal/Abnormal

- Cranial nerves
 Coordination
 Reflexes

Other: _____
 Primary MR Etiology/Category (If known): _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ **DATE:** ____/____/____

EXAMINER'S NAME: _____

Address: _____ **Phone:** _____

RELEASE FORM

I, undersigned, represent and warrant that, to the best of my knowledge and belief, I am/my child is/my ward is physically and mentally able to participate in Special Olympics Colorado. With my approval, a licensed physician is authorized to review the health information set forth in this application, and administer a medical examination so as to certify that there is no medical evidence which would preclude me/my child's/my ward's participation. I understand that if I/my child/my ward has Down Syndrome, I/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 Atlanto-axial instability. I am aware that the sports and events for which this radiological examination is required are judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift, snowboarding and soccer team competition.

Special Olympics Colorado has my permission to use my/my child's/my ward's likeness, name, voice and words in television, radio, film, newspaper, magazines and any other media, and in any form, for the purpose of advertising or communicating the purpose and activities of Special Olympics Colorado and/or applying funds to support those purposes and activities.

If a medical emergency should arise during my/my child's/my ward's participation in any Special Olympics Colorado activities and I am not able to give my consent, for whatever reason, I authorize Special Olympics Colorado to take whatever measures are necessary and which it deems advisable, to protect my/my child's/ my ward's health and well-being, including hospitalization.

I have read and fully understand the provisions of the above release and have explained the provisions to my child/ward. I understand that through my signature on this release form, I am agreeing to the above provisions on my own behalf or on the behalf of my child/ward, and hereby give my permission for my child/ward to participate in Special Olympics Colorado games, recreation programs and physical activities.

Clearly Print Athletes Name _____

Signature of Parent/Caregiver/Adult Athlete _____ **Date:** ____/____/____