APPLICATION FOR PARTICIPATION

Special Olympics Colorado

Return all pages to medical@specialolympicsco.org OR mail to 12450 E. Arapahoe Rd. Unit C, Englewood, CO 80112

ATHLETE INFORMATION

Last Name_____ First Name _____ MI_____

Street Address_____ City _____ Zip_____

Home Phone _____ Cell Phone_____ DOB___/___/___

E-Mail Address_____ Gender Male ☐ Female ☐

Ethnicity White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ Other ☐ _____

Employer_____ Position _____

Dates of Employment_____ to _____ Work Phone _____

Local Program/Team/School:_____

DOES THE ATHLETE HAVE (Check any that apply):

☐Autism ☐Cerebral Palsy ☐Down Syndrome ☐Fetal Alcohol Synd. ☐Fragile X Syndrome Other_____

PARENT/CAREGIVER#1 INFORMATION

Last Name_____ First Name _____

Street Address_____ City _____ Zip _____

Home Phone_____ Cell Phone _____

E-Mail Address_____

Employer_____ Position_____

Does your employer have a Giving/Corporate Matching Program? Yes ☐ No ☐

**This information is strictly confidential and is collected for grant reporting purposes only. Your personal data will not be shared or used to identify you.

PARENT/CAREGIVER #2 INFORMATION

Last Name_____ First Name _____

Street Address_____ City _____ Zip _____

Home Phone_____ Cell Phone _____

E-Mail Address_____

Employer_____ Position_____

Does your employer have a Giving/Corporate Matching Program? Yes ☐ No ☐

HEALTH INSURANCE/EMERGENCY CONTACT INFORMATION

Emergency Contact_____ Phone Number _____

Do you have health insurance? Yes ☐ No ☐

Medical Insurance Company _____ Policy Number _____

RETURN ALL PAGES TO MEDICAL@SPECIALOLYMPICSCO.ORG OR 12450 E. ARAPAHOE RD. UNIT C, ENGLEWOOD, CO 80112

LAST NAME_____ FIRST NAME_____

MEDICATIONS (PLEASE ATTACH AN ADDITIONAL SHEET IF NECESSARY)

Medication Name	Dosage	Date Prescribed	Times Per Day

HEALTH HISTORY

Heart Disease/Heart Defect/High Blood Pressure Select

Chest Pain Select

Seizures/Epilepsy/Fainting Spells Select

Diabetes Select

Concussion/Serious Head Injury Select

Concussion Symptoms Select

Major Surgery/Serious Illness Select

Emotional/Psychiatric/Behavioral Select

Blindness/Visual Problem Select

Heat Stroke/Exhaustion Select

Hearing Loss/Hearing Aid Select

Immunizations Up to Date Select

Date of Most Recent Tetanus Immunization _____/_____/_____

Allergies Select

Medicines Select

Food Allergies Select

Insect Stings/Bites Select

Assistive Devices Select

Easy Bleeding Select

Visually Impaired Select

Sickle Cell Trait Disease Select

Contact Lenses/Glasses Select

Bone/Joint Problem Select

Non-Verbal Select

Additional Comments:_____

RETURN ALL PAGES TO MEDICAL@SPECIALOLYMPICSCO.ORG OR 12450 E. ARAPAHOE RD. UNIT C, ENGLEWOOD, CO 80112

LAST NAME_____ FIRST NAME_____

RELEASE FORM

I, the 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, licensed physicians 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/my ward from 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. **Initial**_____

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. **Initial**_____

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. **Initial**_____

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 my local Area Manager if I have any questions about housing arrangements for a specific event or the housing policy in general. **Initial**_____

I acknowledge that Special Olympics requires each coach to pass an approved concussion awareness and safety recognition program and I have read the policy as posted on. www.specialolympicsco.org. **Initial**_____

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. **Initial**_____

Clearly Print Athlete Name_____

Signature of Adult Athlete/Parent/Caregiver_____ Date_____/_____/_____

RETURN ALL PAGES TO MEDICAL@SPECIALOLYMPICSCO.ORG OR 12450 E. ARAPAHOE RD. UNIT C, ENGLEWOOD, CO 80112

PHYSICAL EXAMINATION – TO BE COMPLETED BY LICENSED PHYSICIAN

LAST NAME_____ FIRST NAME_____ DOB_____

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian,

prior to performing the physical exam.

Blood Pressure_____/_____ Weight_____ Height_____ BMI_____

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
_____	_____	Vision	_____	_____	Cardiovascular System	_____	_____	Cranial Nerves
_____	_____	Hearing	_____	_____	Respiratory System	_____	_____	Coordination
_____	_____	Oral Cavity	_____	_____	Gastrointestinal System	_____	_____	Reflexes
_____	_____	Neck	_____	_____	Genitourinary System	_____	_____	Skin
_____	_____	Extremities						

Notes:

_____ **Athlete does not have any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.**

_____ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and therefore must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete is deemed to need further medical evaluation, please provide them with the necessary referrals.

_____ **This athlete IS ABLE to participate in Special Olympics sports.**

Limitations or Restrictions: _____

_____ **This athlete MAY NOT participate in Special Olympics sports at this time and must be evaluated by a physician for the following concerns:**

_____Concerning Cardiac Exam _____Acute Infection _____Oxygen Saturation Less Than 90% on Room Air

_____Concerning Neurological Exam _____Stage II Hypertension or greater _____Hepatomegaly or Splenomegaly

_____Other, please describe_____

ADDITIONAL LICENSED EXAMINER'S NOTES – FOLLOW UP WITH A:

_____Cardiologist _____Neurologist _____Primary Care Physician _____Vision Specialist

_____Hearing Specialist _____Dentist/Hygienist _____Podiatrist _____Physical Therapist

_____Nutritionist _____Other_____

Licensed Medical Examiner's Signature **NAME**_____

_____ **E-MAIL**_____

LICENSE #_____ **PHONE**_____ **DATE**_____

RETURN ALL PAGES TO MEDICAL@SPECIALOLYMPICSCO.ORG OR 12450 E. ARAPAHOE RD. UNIT C, ENGLEWOOD, CO 80112

This information is optional and strictly confidential and is collected for grant reporting purposes only. Your personal data will not be shared or used to identify you.

Ethnicity

- ☐ White/Caucasian
- ☐ African-American
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Other

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Transgender

Education

Are you currently a student? Yes ☐ No ☐ Grade_____

School Name _____ City _____

Athlete Income

Do you have a job? Yes ☐ No ☐

- ☐ I earn less than $12,000 per year.
- ☐ I earn more than $12,000 per year.

Household

Income of athlete's family.

- ☐ $0 - $24,000
- ☐ $25,000 - $49,000
- ☐ $50,000 - $99,000
- ☐ $100,000 +

Living Situation

Where do you live?

- ☐ Independently in my own home or apartment
- ☐ With my parents/family
- ☐ Group home/ residential facility.
- ☐ Host home or with a care provider.

Government Support

Do you currently receive government support?

Yes ☐ No ☐

- ☐ SSI
- ☐ SNAP
- ☐ Medicaid
- ☐ Other

Please describe:

_____