APPLICATION FOR PARTICIPATION

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

Special Olympics Colorado

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 (CIRCLE ANY THAT APPLY):

Autism Cerebral Palsy Down Syndrome Fetal Alcohol Syndrome 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_____________________

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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	Yes	No	Allergies	Yes	No
Chest Pain	Yes	No	Medicines	Yes	No
Seizures/Epilepsy/Fainting Spells	Yes	No	Food Allergies	Yes	No
Diabetes	Yes	No	Insect Stings/Bites	Yes	No
Concussion/Serious Head Injury	Yes	No	Assistive Devices	Yes	No
Concussion Symptoms	Yes	No	Easy Bleeding	Yes	No
Major Surgery/Serious Illness	Yes	No	Visually Impaired	Yes	No
Emotional/Psychiatric/Behavioral	Yes	No	Sickle Cell Trait Disease	Yes	No
Blindness/Visual Problem	Yes	No	Contact Lenses/Glasses	Yes	No
Heat Stroke/Exhaustion	Yes	No	Bone/Joint Problem	Yes	No
Hearing Loss/Hearing Aid	Yes	No	Non-Verbal	Yes	No
Immunizations Up to Date	Yes	No	Other____________	Yes	No
Date of Most Recent Tetanus Immunization	____/____/____		______________________________		

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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_____/_____/_____

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PHYSICAL EXAMINATION – TO BE COMPLETED BY LICENSED PHYSICIAN

LAST NAME__________________________________ FIRST NAME_____________________________ DATE OF BIRTH_____________

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						

______ 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. (Please note any 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__________________

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Ethnicity

________ White/Caucasian

________ Black/African-American

________ Asian

________ Hispanic/Latino

________ Other

Gender Identity

________Male

________Female

________Transgender

Education

Are you currently a student? Yes________ No________

School Name________________ City________________ Grade________

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________________________