APPLICATION FOR PARTICIPATION

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_____

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	____/____/____		_____		

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_____/_____/_____

NOTE: If you are submitting this form electronically, please authorize with your initials below instead of utilizing the signature line.

Adult Athlete/Parent/Caregiver Initial _____ Date_____/_____/_____

LAST NAME_____ **FIRST NAME**_____

PHYSICAL EXAMINATION – TO BE COMPLETED BY LICENSED PHYSICIAN

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-Americn

_____ 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 +

Government Support

Do you currently receive government support?
Yes_____ No_____

_____SSI

_____SNAP

_____Medicaid

_____Other

Please describe_____

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.