

## Special Olympics Kansas Medical / Release Form

Each participant in Special Olympics MUST have a current medical / release form on file in the SOKS Headquarters Office and in the possession of the coach prior to participating in any Special Olympics event/training/competition.

### DEMOGRAPHICS

TEAM NAME: _____	NUMBER: _____
Athlete's Social Security # _____ - _____ - _____ (if US Citizen)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Athlete's Name _____	Date of Birth (month/day/year) _____/_____/_____
Athlete's Address _____	Athlete Home Phone # _____ ( ) _____
City: _____ State: _____ Zip: _____	Parent Email Address _____
Parent/Guardian's Name _____	Parent Primary Phone # _____ ( ) _____
Parent/Guardian's Address (if different than athlete) _____	Parent Cell Phone # _____ ( ) _____
Emergency Contact (if other than parent/guardian) _____	Parent Secondary Phone # _____ ( ) _____
Health/Accident Insurance Company _____	Parent Employer _____
	Emergency Phone #/Cell _____ ( ) _____
	Policy # _____

**PARTICIPATION AND CONSENT TO TREATMENT:** I hereby give permission for the participant named above to participate in Special Olympics. To the best of my knowledge, the athlete is physically and mentally able to participate in Special Olympics and full disclosure of the participant's medical history has been made to the physician whose signature appears below. I acknowledge that the participant will be using facilities at his own risk and said parent/guardian, on his behalf, hereby releases, discharges and indemnities Special Olympics from all liability for injury to person or damage to property of himself and applicant. I hereby irrevocably grant Special Olympics permission to record the above participant's likeness and/or voice for use by television, films, radio or printed media to further the aims of the Special Olympics. If I am not personally present at Special Olympics activities, 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 participant.

### HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 5%;">Yes</th> <th style="width: 5%;">No</th> <th style="width: 90%;"></th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Heart disease / heart defect / high blood pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Chest pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Seizures / epilepsy/fainting spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Concussion or serious head injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Major surgery or serious illness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Blindness / visual problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>*Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heat stroke / exhaustion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Contact lenses / glasses</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hearing loss / hearing aid</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or joint problem</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	*Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	*Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	*Seizures / epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	*Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	*Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	*Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	*Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 5%;">Yes</th> <th style="width: 5%;">No</th> <th style="width: 90%;"></th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergy: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Medicines: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Food: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Insect stings/bites: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Special diet</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tobacco use</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Easy bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Emotional / psychiatric / behavioral</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sickle cell trait or disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Immunizations up to date</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Wheelchair</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other (for additional space, use back of form): _____</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Allergy: _____	<input type="checkbox"/>	<input type="checkbox"/>	Medicines: _____	<input type="checkbox"/>	<input type="checkbox"/>	Food: _____	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites: _____	<input type="checkbox"/>	<input type="checkbox"/>	Special diet	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Emotional / psychiatric / behavioral	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	Other (for additional space, use back of form): _____
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Date of most recent tetanus immunization \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(\* Requires physical examination)

**Medications:**

Please print medication name, amount, 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

**NOTE:** If there is any significant change in the athlete's health, the athlete's condition **should** be reviewed by a physician before further participation.

**PARENT / GUARDIAN / ADULT PARTICIPANT SIGNATURE** \_\_\_\_\_

**DOWN SYNDROME:**  YES  NO **CHECK ONE:** ATLANTO-AXIAL  NEG.  POS.

**NOTE** If the athlete has Down syndrome, Special Olympics requires that the athlete have a full radiological examination establishing the degree, if any, of Atlanto-Axial instability before he / she may participate in any Special Olympics sport or event. Down syndrome forms are available from SOKS office.

**MEDICAL CERTIFICATION**

A physical examination can only be conducted by a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Physician's Assistant, or an Advanced Registered Nurse Practitioner (ARNP).

### PHYSICAL EXAMINATION

Blood pressure: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Normal/Abnormal <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Oral cavity <input type="checkbox"/> Neck <input type="checkbox"/> Extremities	Normal/Abnormal <input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Respiratory system <input type="checkbox"/> Gastrointestinal system <input type="checkbox"/> Genitourinary system <input type="checkbox"/> Skin	Normal/Abnormal <input type="checkbox"/> Cranial nerves <input type="checkbox"/> Coordination <input type="checkbox"/> Reflexes
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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:** \_\_\_\_\_ ( ) \_\_\_\_\_