ATHLETE MEDICAL – RELEASE FORM

Special Olympics Kentucky

For questions please call: **(502)695-8222 / (800)633-7403**

PLEASE FILL OUT COMPLETELY

ATHLETE INFORMATION

First/Given Name:	Middle Name:	Last/Family Name:
Address:		Suffix: (Jr., III, etc.)
City:	State: Zip:	County:
Gender: ☐ Male ☐ Female	Birthdate (mm/dd/yy): / /	Wheelchair Athlete: ☐ Yes ☐ No
Home Phone:	Cell Phone:	Work Phone:
E-mail Address:		
Name of Parent of Guardian:		Phone: ( )
Address:	City/State/Zip:	

Has this individual participated in Special Olympics within the past 5 years? ☐ **Yes** ☐ **No**

EMERGENCY INFORMATION

Emergency Contact: Emergency Phone:

HEALTH AND ACCIDENT INSURANCE INFORMATION

Company Name: Policy #:

FOR DOWN SYNDROME ATHLETES ONLY: ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

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

***THIS ASSESSMENT IS REQUIRED ONLY ONCE UNLESS MEDICALLY INDICATED OTHERWISE.**

☐ Yes ☐ No Has an x-ray evaluation for atlanto-axial instability been done?

☐ Yes ☐ No If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Temperature: _____ Pulse: _____ Blood Pressure: _____/_____ Weight: _____ Height: _____

ONLY CHECK THE BOXES IF ANY OF THE SYMPTOMS BELOW ARE ABNORMAL.

☐ Vision ☐ Hearing ☐ Oral Cavity ☐ Neck ☐ Extremities ☐ Cardiovascular system ☐ Respiratory system ☐ Gastrointestinal system
☐ Genitourinary system ☐ Skin ☐ Cranial nerves ☐ Coordination ☐ Reflexes

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

I am a PHYSICIAN/PA/ARNP and have reviewed the above health information and have performed the above examination on this athlete within the past 12 months and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

⇨ **PHYSICIAN/PA/ARNP SIGNATURE:** _____ **Date:** ___ / ___ / ___

Physician/PA/ARNP Name (Please Print): _____

Address: _____ City/State/Zip: _____ Phone: (_____)

ALL ATHLETES MUST HAVE A PHYSICIAN's, PA's, or ARNP's SIGNATURE ON THEIR ATHLETE MEDICAL-RELEASE FORM.

HEALTH HISTORY: TO BE COMPLETED BY PHYSCIIAN/PA/ARNP/PARENT/CARGIVER or ADULT ATHLETE 18 YEARS OR OLDER

Specific diagnosis if known: _____

		YES	NO
1.	Heart Disease/Heart Defect/High Blood Pressure	1. _____	_____
2.	Seizures/Epilepsy/Fainting Spells	2. _____	_____
3.	Down Syndrome	3. _____	_____
4.	Diabetes	4. _____	_____
5.	Concussion or serious illness	5. _____	_____
6.	Major surgery or serious illness	6. _____	_____
7.	Chest Pain	7. _____	_____
8.	Asthma	8. _____	_____
9.	Blindness	9. _____	_____
10.	Deaf/Complete Hearing Loss	10. _____	_____
11.	Heat stroke/exhaustion	11. _____	_____
12.	Allergy (list specific)	12. _____	_____
	Medicine _____		
	Foods _____		
	Insect Stings/Bites _____		
	General _____		

		YES	NO
13.	Special Diet _____	13. _____	_____
14.	Tobacco Use	14. _____	_____
15.	Easy bleeding	15. _____	_____
16.	Emotional/psychiatric/behavioral problems	16. _____	_____
17.	Bone or Joint problem	17. _____	_____
18.	Sickle cell trait or disease	18. _____	_____
19.	Hearing Impaired/Hearing Aid/Hearing Loss	19. _____	_____
20.	Contact lenses/Eyeglasses	20. _____	_____
21.	Hepatitis	21. _____	_____
22.	Non-Verbal	22. _____	_____
23.	Immunizations (shots) are up-to-date	23. _____	_____
24.	Date of last Tetanus Shot ___ / ___ / ___	24. _____	_____

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

SPECIAL OLYMPICS KENTUCKY OFFICIAL RELEASE
TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE OR ADULT ATHLETE 18 YEARS OR OLDER

I am the parent/guardian or at least 18 years old and my own guardian and have submitted the attached application for participation in Special Olympics. Permission has been given for the above listed person to participate in Special Olympics activities.

I further represent and warrant that to the best of my knowledge and belief, the above listed person is physically and mentally able to participate in Special Olympics. With my approval, a licensed medical professional has reviewed the health information set forth in the Athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the Athlete's participation. I understand that if the above listed person has Down Syndrome, 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 I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction, or the Athlete has had a full radiological examination, which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, the above listed person must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and soccer.

In permitting the above listed person to participate, I am specifically granting my permission, forever, to Special Olympics to use the Athlete's likeness, name, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

By signing below, I am also permitting the above listed person to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand that notwithstanding my consent, there is no obligation for the Athlete to participate in the Healthy Athletes Program and that I may decide that the Athlete will not participate. I understand that provision of these health services is not intended as a substitute for regular care. I also understand that the above listed person should seek his/her own medical advice and assistance irrespective of the provision of these services and that Special Olympics through the provision of these services is not making itself responsible for Athlete's health.

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 Special Olympics Kentucky or my Local Program if I have any questions about housing arrangements for a specific event or the housing policy in general.

If a medical emergency should arise during the Athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the Athlete's care, I hereby authorize Special Olympics Kentucky, on my behalf, to take whatever measures are necessary to ensure that the Athlete is provided with any emergency medical treatment, including hospitalization, that Special Olympics deems advisable in order to protect the Athlete's health and well-being. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE *SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT* FORM)**

I am the parent (guardian) of the Athlete named in this application or at least 18 years old and my own guardian. I have read and fully understand the provisions of the above release, and have explained these provisions to the above listed person. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the Athlete named above.

I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Caregiver/Adult Athlete *(if own legal guardian)*: _____ **Date:** _____

Witness Signature: _____ Date: _____

Witness Name (Print): _____ Witness Relationship to Athlete: _____

Mail original white copy of form to: Athlete Medical, Special Olympics Kentucky, 105 Lakeview Court, Frankfort, KY 40601-8749
If time sensitive please Fax to: (502)695-0496
Please give Official/Coach the Yellow copy of this form