# Athlete Enrollment/Medical Release Form

(The form must be completely filled out or it will be returned.)

Check One: ☐ Renewal ☐ New ☐ Updated Submission Date: _____

A: Athlete's Name: _____ Home Phone: (____) _____

Sex: _____ Age: ____ Date of Birth: _____ / _____ / _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Solely to help us comply with government record keeping, reporting and other legal requirements, please check what applies:

☐ White ☐ Black ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Asian Pacific Islander ☐ Other _____

B: Head of Delegation: _____ Delegation Code: _____

Cell Phone: (____) _____ E-mail: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

C: Parent/Guardian Name: _____ E-mail: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Street Address: _____

City: _____ State: _____ ZIP: _____

D: Person to Notify in Case of an Emergency ☐ (Check if it is the same as above.)

Name: _____ Relationship to Athlete: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Street Address: _____

City: _____ State: _____ ZIP: _____

E: Name of Person Completing this Form: _____

| Physical Examination | Normal/Abnormal | Normal/Abnormal | Normal/Abnormal |
|---|---|---|---|
| Athlete's height: _____ | ☐ ☐ Vision | ☐ ☐ Cardiovascular system | ☐ ☐ Cranial nerves |
| Weight: _____ | ☐ ☐ Hearing | ☐ ☐ Respiratory system | ☐ ☐ Coordination |
| Blood pressure: ____/_____ | ☐ ☐ Oral cavity | ☐ ☐ Gastrointestinal system | ☐ ☐ Reflexes |
| | ☐ ☐ Neck | ☐ ☐ Genitourinary system | ☐ ☐ Extremities |
| | ☐ ☐ Skin | | |

| | | | |
|---|---|---|---|
| 1. Heart disease/heart defect/high blood pressure | ☐ Yes | ☐ No | ☐ New Problem |
| 2. Chest pain or fainting spells | ☐ Yes | ☐ No | ☐ New Problem |
| 3. Seizures/Epilepsy | ☐ Yes | ☐ No | ☐ New Problem |
| 4. Diabetes | ☐ Yes | ☐ No | ☐ New Problem |
| 5. Concussion or serious head injury | ☐ Yes | ☐ No | ☐ New Problem |
| 6. Major surgery or serious illness | ☐ Yes | ☐ No | ☐ New Problem |
| 7. Heat exhaustion/stroke | ☐ Yes | ☐ No | ☐ New Problem |
| 8. Visually impaired/contact lenses/glasses | ☐ Yes | ☐ No | ☐ New Problem |
| 9. Blindness/major visual problem | ☐ Yes | ☐ No | ☐ New Problem |
| 10. Hearing impaired/hearing aid/hearing loss | ☐ Yes | ☐ No | ☐ New Problem |
| 11. Deaf/complete hearing loss | ☐ Yes | ☐ No | ☐ New Problem |
| 12. Serious bone or joint disorder | ☐ Yes | ☐ No | ☐ New Problem |
| 13. Allergic to the following: | | | |
| Medicines: _____ | | | |
| Foods: _____ | | | |
| Insect sting/bite: _____ | | | |
| 14. Special diet: _____ | | | |
| 15. Asthma | ☐ Yes | ☐ No | ☐ New Problem |
| 16. Tobacco use | ☐ Yes | ☐ No | |
| 17. Tendency to bleed easily | ☐ Yes | ☐ No | ☐ New Problem |
| 18. Emotional problems/psychiatric disorder | ☐ Yes | ☐ No | ☐ New Problem |
| 19. Sickle Cell trait or disease | ☐ Yes | ☐ No | ☐ New Problem |
| 20. Immunizations are up to date | ☐ Yes | ☐ No | ☐ New Problem |
| 21. Date of last tetanus: _____/_____/_____ | | | |
| 22. Down syndrome | ☐ Yes | ☐ No | |
| Have cervical spine (neck/bone) xrays been done? | ☐ Yes | ☐ No | |
| Atlantoaxial Instability | ☐ Yes | ☐ No | |

**Please check any of the following that apply:**

☐ Non Verbal ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Hepatitis ☐ Shunts

### Please Note

* An up-to-date health history and a physical examination performed by a licensed physician is required upon entry into the program.
* A physical examination is required every 3 years for items 1- 4, 22
* A physical examination is required for all athletes with a "new problem" response to items 6 - 10.
* Athletes must submit a Medical Release Form every 3 years whether or not an examination is needed.

### Current Prescription Medication

* First Medication: _____
  Amount: _____
  Time: _____
  Date Prescribed: ____/_____/_____

* Second Medication: _____
  Amount: _____
  Time: _____
  Date Prescribed: ____/_____/_____

* Third Medication:_____
  Amount: _____
  Time: _____
  Date Prescribed: ____/_____/_____

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### MEDICAL CERTIFICATION

**Note to Physicians:** If the athlete has Down syndrome, Special Olympics Texas requires that the athlete have a full radiological examination establishing the absence of Atlantoaxial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radial flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: equestrian, gymnastics, diving, pentathlon, butterfly stroke, and diving starts in aquatics,high jump, flag football and soccer and warm-up exercises placing undue stress on head or neck.

**Check Here:** ☐ I have reviewed the above information on and examined the athlete named in the application, and certify there is not medical evidence available to me that would preclude the athlete's participation in Special Olympics Texas.

Restrictions: _____

Physician's Name (print): _____

Physician assistant licensed by State Board of Physician Assistant Examiners or registered nurse recognized as an advanced practice nurse by the Board of Nurse Examiners.

Physician's Signature: _____ Date: _____

Address: _____ City: _____ State: ____ ZIP: _____

Physician's Phone: (_____) _____

Please provide name of athlete's insurance company: _____

Please provide medical insurance company's phone number: _____

It is understood and agreed that: If the examiner is provided free of charge, it is not intended to be a thorough or comprehensive examination. No physician-patient relationship is to arise out of the examination. The doctor, nurse or other person involved in the examination is under no obligation to provide a diagnosis, treatment, advice, consultation or any follow-up care whatsoever under any circumstances. The fact that any person is cleared or authorized to participate in any sport or other activity does not mean and is not to be interpreted as the opinion of the doctor or nurse that the person examined is healthy, in need of no care, or can participate in any sport or other activity without serious medical risks. Any claim against the doctor, nurse or other person involved in the examination will be submitted to binding arbitration pursuant to the rules and procedures of the American Arbitration Association. The person examined and any person who signs on his or her behalf promises to indemnify the doctor or nurse from any and all damages, claims, or losses, including injury or death that allegedly arise out of or are in any way related to the examination.

Participation: I hereby give my permission for the participant named above to participate in any Special Olympics activity or event of any kind. I understand that participation at local or area competition does not guarantee advancement to State or World Games. Athletes must be registered using this release form prior to any athlete training.

Medical: I represent and warrant to you that the athlete is physically and mentally able to participate in Special Olympics Texas.

Disclaimer: On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release the physicians, organizers, officers, directors, agents or employees of Special Olympics Texas from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or the athlete.

Hospitalization: If I am not personally present at the event in which the athlete is to compete so as to be consulted in case of emergency, you are authorized on my behalf and at my account to take such measure and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete.

Media: In permitting the athlete to participate, I am specifically granting permission to you to use the name, likeness, voice and words of the athlete in television, radio, films, newspapers, magazines, web pages and other media, and in any form not hereto fore described for the purpose of advertising or communicating the purposes and activities of Special Olympics Texas and in appealing for funds to support such activities.

**SOTX Housing Policy:** For any overnight trip, a gender-specific athlete to chaperone ratio of 4 to 1 is required (see SIG page N-8 for specific breakdown). No athletes or volunteers of opposite genders may room together. The only exceptions are: if the athletes/volunteers are married; or if a family member of the opposite gender is chaperoning. Unified Partners under the age of 17 should be included in the ratio as in need of a chaperone.

**Check One:** ☐ Parent ☐ Guardian ☐ Athlete (if over the age of 18)

Parent/Guardian/Athlete Signature:_____

Print Name of Above: _____

Street Address:_____

City:_____State:_____ ZIP: _____

Please list sports in which athlete will compete:_____ _____

***All coaches will be responsible for having up-to-date Application for Participation Forms in their possession at training and competition events and during transportation and travel.***