U.S. Athlete Registration Form

Special Olympics

Required for all athletes participating in Special Olympics.

Local Special Olympics Program: _____

Athlete Information - *To be completed by the athlete or parent/guardian/caregiver.*

First name: _____ Last name: _____ Middle name: _____

Date of birth (dd/mm/yyyy): ____/____/_____ Gender: ○ Female ○ Male ○ Other

Email: _____ Phone number: _____ ○ Mobile ○ Landline

Home address: _____

Optional – *Check all that apply:*		
Race / Ethnicity	☐ American Indian / Alaskan Native ☐ Black / African American ☐ Middle Eastern / North African ☐ White / Caucasian ☐ Other: _____	☐ Asian American ☐ Hispanic / Latino ☐ Native Hawaiian / Other Pacific Islander ☐ Unknown ☐ Prefer not to answer
Language(s) Spoken by Athlete	☐ English ☐ French ☐ Spanish ☐ American Sign Language (ASL) ☐ Other (please list): _____	

Parent/Guardian Information - *Required if minor or otherwise has a legal guardian.*

First Name: _____ Last Name: _____ Relationship to athlete: _____

Email: _____ Phone number: _____ ○ Mobile ○ Landline

Home address: _____

Emergency Contact ☐ *Same as Parent/Guardian*

First name: _____ Last name: _____ Phone number: _____ ○ Mobile ○ Landline

Relationship to athlete: ○ Parent/guardian ○ Caregiver ○ Family member ○ Healthcare provider ○ Coach ○ Other

Associated Conditions - ***Mandatory***

Associated Conditions ***Check all that apply:***	☐ Autism ☐ Cerebral Palsy ☐ Down Syndrome ☐ Fetal Alcohol Syndrome ☐ Marfan Syndrome ☐ Spina Bifida ☐ Epilepsy ☐ Fragile X Syndrome ☐ Other ☐ Unknown
Please specify other known intellectual disability diagnoses:	

Assistive Devices and Accommodations - *Do you use any of the following? Check all that apply:*

Mobility	☐ Walker ☐ Braces or crutches ☐ Wheelchair ☐ Removable orthotics ☐ Prosthetics ☐ None
Lifestyle Aids	☐ CPAP ☐ Dentures ☐ Glasses, contact lenses, or protective eyewear ☐ None
Communications	☐ Hearing Aid ☐ Communication devices ☐ Sign Language ☐ None
Medical Devices	☐ Implantable cardioverter defibrillator (ICD) ☐ Implantable device for seizure management ☐ VP Shunt ☐ Pacemaker ☐ None

Do you have a specific dietary requirement?	○ Yes ○ No	If yes, please specify:
Do you use other assistive devices?	○ Yes ○ No	If yes, please specify:

General Health Questions

Do you have a heart condition?	◯ Yes	◯ No
Do you have asthma?	◯ Yes	◯ No
Do you have diabetes that requires you to take insulin?	◯ Yes	◯ No
Do you have a vision impairment?	◯ Yes	◯ No
Do you have a hearing impairment?	◯ Yes	◯ No
Do you have a bleeding disorder?	◯ Yes	◯ No
Has a doctor ever limited your participation in sports?	◯ Yes	◯ No
Do you have epilepsy or any type of seizure disorder?	◯ Yes	◯ No
Do you have sickle cell disease?	◯ Yes	◯ No

Have you ever had a concussion?	◯ Yes ◯ No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	◯ Yes ◯ No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	◯ Yes ◯ No	If yes, please specify if it is to any of the following: ☐ Insect stings ☐ Medication/drugs ☐ Food ☐ Latex ☐ Other (please specify): _____

Medication and Treatment - *Please list:*

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

◯ Yes ◯ No

If yes, please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: _____

Today's date (dd/mm/yyyy): _____/_____/_____

Is this form being completed by someone other than the athlete? ◯ Yes ◯ No

If yes, please select the relationship to athlete:

Relationship to athlete: ◯ Parent/guardian ◯ Caregiver ◯ Family member ◯ Healthcare provider ◯ Coach ◯ Other

Special Olympics encourages all participants to get a yearly physical examination.

WAIVERS, RELEASES, AND POLICIES

Please read the following information and check boxes fully before signing.

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.

2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.

3. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment.

   ☐ I do not consent to blood transfusions.

   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

4. **Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.

5. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."

6. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").

I agree and consent to Special Olympics:

- using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.

- using my contact information for communicating with me about Special Olympics.

- sharing my personal information confidentially with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.

- I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.

Privacy Policy. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY
(For athlete with Down syndrome only)

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION

In consideration of being allowed to participate in any way in Special Olympics activities, the undersigned acknowledges, appreciates, and agrees that:

1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;

2. If I observe any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest Special Olympics representative immediately; and,

3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

Athlete Name: _____

ATHLETE SIGNATURE
(required for adult athlete with capacity to sign legal documents)

I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.

Athlete Signature: _____ Date (dd/mm/yyyy): _____/_____/_____

PARENT/GUARDIAN SIGNATURE
(required for athlete who is a minor or lacks capacity to sign legal documents)

I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.

Parent/Guardian Signature: _____ Date (dd/mm/yyyy): _____/_____/_____

Printed Name: _____ Relationship: _____

EVALUATION AND RESEARCH
(Optional)

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

○ Yes ○ No

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name: _____ Date of birth (mm/dd/yyyy): ____/____/_____

Height (in/cm)	Weight (lb/kg)	Waist circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Medical			
Eyes, ears, nose, and throat: include pupils, hearing	Normal ☐	Abnormal ☐	Findings:
Heart: include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)	Normal ☐	Abnormal ☐	Findings:
Lungs	Normal ☐	Abnormal ☐	Findings:
Abdomen	Normal ☐	Abnormal ☐	Findings:
Skin: HSV, MRSA, or tinea corporis	Normal ☐	Abnormal ☐	Findings:
Neurological	Normal ☐	Abnormal ☐	Findings:
Musculoskeletal			
Neck	Normal ☐	Abnormal ☐	Findings:
Back	Normal ☐	Abnormal ☐	Findings:
Shoulder and arm	Normal ☐	Abnormal ☐	Findings:
Elbow and forearm	Normal ☐	Abnormal ☐	Findings:
Wrist, hand, and fingers	Normal ☐	Abnormal ☐	Findings:
Hip and thigh	Normal ☐	Abnormal ☐	Findings:
Knee	Normal ☐	Abnormal ☐	Findings:
Lower leg and ankle	Normal ☐	Abnormal ☐	Findings:
Foot and toes	Normal ☐	Abnormal ☐	Findings:

MEDICAL ELIGIBILITY FOR SPORT *(TO BE COMPLETED BY EXAMINER ONLY)*

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 needs further medical evaluation, please provide information regarding the licensed healthcare provider below. That provider should complete a referral below and second physician for referral should complete page 4.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____

☐ Not medically eligible pending further evaluation of: _____

☐ Not medically eligible to participate in the following sports: _____

☐ Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date (mm/dd/yyyy): ___/___/_____

Address: _____ Phone: _____

Signature of health care professional: _____

NPI or License number: _____ License type (MD, DO, NP, or PA): _____