Circle One

NEW RENEWAL

APPLICATION FOR PARTICIPATION (Medical Form

(must be completed and signed by licensed examiner every 3 years)

Special Olympics Florida

REQUIRED

COUNTY _____ School/Agency:_____

T-shirt Size: Children:_____ OR Adult:_____

LAST NAME_____ FIRST_____ SEX/DATE OF BIRTH **(REQUIRED)**

M or F month/day/year

Street Number/Address_____ _____ _____/_____/_____

City_____ State _____ Zip Code_____ Email _____

Parent/Guardian_____ Cell Phone (_____) _____

Address (if different)_____ Home Phone (_____) _____

City_____ State_____ Zip Code_____ P/G Email _____

Emergency Contact (other than parent/guardian)_____ Emerg. Phone (_____) _____

Health Insurance Company_____ Ins. Policy #_____

REQUIRED → Signature of parent/legal guardian/adult athlete completing form_____

REQUIRED → ALSO PRINT NAME _____

FOR ATHLETES WITH DOWN SYNDROME -- Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

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

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

IS THERE PRESENT OR A HISTORY OF (to be completed by parent/caregiver):

Blind	☐ Yes	Tobacco use	☐ Yes	Emotional/psychiatric/behavioral problems	☐ Yes
Deaf	☐ Yes	Major surgery or serious illness	☐ Yes	Asthma/breathing problems with exertion	☐ Yes
Heart problems/high blood pressure	☐ Yes	Heat stroke/exhaustion	☐ Yes	Contact lenses/glasses/dentures/false teeth	☐ Yes
Seizures/epilepsy/fainting spells	☐ Yes	Easy bleeding	☐ Yes	Head injury/history of concussion	☐ Yes
Diabetes	☐ Yes	Bone/joint problems	☐ Yes	Immunizations (shots) are up-to-date	☐ Yes
Hearing aid/hearing problems	☐ Yes	Sickle cell disease or trait	☐ Yes	Special Diet Needs (list below)	☐ Yes
Blindness/vision problem	☐ Yes	Uses a wheelchair	☐ Yes	Year of last tetanus shot_____	

Other problems that would interfere with participation _____

Allergy to the following (list specific):

Food_____ Insect sting/bites_____

Medication_____

MEDICATIONS

Medication Name	Dosage	Date Presc.	Times per day	Medication Name	Dosage	Date Presc.	Times per day

PHYSICAL EXAMINATION

		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Blood Pressure _____	Vision	☐	☐	Oral Cavity	☐	☐	Cardiovascular system	☐	☐
Pulse _____	Hearing	☐	☐	Extremities	☐	☐	Respiratory system	☐	☐
Weight _____	Neck	☐	☐	Coordination	☐	☐	Gastrointestinal system	☐	☐
Height _____	Skin	☐	☐	Reflexes	☐	☐	Genitourinary system	☐	☐
							Cranial nerves	☐	☐

REQUIRED: PRIMARY ETIOLOGY/CATEGORY- INTELLECTUAL/DEVELOPMENTAL DISABILITY_____

OTHER: _____

I have reviewed the above health information and examined the athlete named in the application and certify that there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions_____

REQUIRED Examiner's Name:_____ Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP

REQUIRED EXAMINER'S SIGNATURE_____ **REQUIRED DATE:**_____

OPTIONAL INFORMATION

Ethnic background: ☐○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Other_____