

HEALTH PROGRAMS CONSENT FORM



Athlete's Name (please print): _____
First Last

Date of Birth: ____/____/____ County: _____
Month Day Year

1. **Ability to Participate.** I am physically able to take part in Special Olympics Health Activities.
2. **Likeness Release.** Special Olympics has permission (both during and any time after) to use my (or my minor child's) likeness, photo, name, voice and words, in any form, to promote Special Olympics and raise funds, for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **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. (Not common)
 - I do not consent to blood transfusions. (Not common)
 (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
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 can say no to treatment or anything else 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; provide health treatment if I participate in a health program; and analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants.
7. **Miscellaneous.** I understand that there is no obligation for me to participate should I decide not to. Provision of these health services is not intended as a substitute for regular medical care and I understand I should seek my own independent medical advice and assistance.

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| Athlete Name: | E-mail: |
| 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: |
| 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: |
| Printed Name: | Relationship: |

NOTE: This authorization shall remain effective unless the consenting party requests termination or the scope of the Healthy Athletes program changes materially.