

**Circle One**

**NEW RENEWAL**

**APPLICATION FOR PARTICIPATION (Medical Form)**  
(must be completed and signed by licensed examiner every 3 years)



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

Blood Pressure _____	Vision	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Oral Cavity	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Cardiovascular system	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>
Pulse _____	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory system	<input type="checkbox"/>	<input type="checkbox"/>
Weight _____	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal system	<input type="checkbox"/>	<input type="checkbox"/>
Height _____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary system	<input type="checkbox"/>	<input type="checkbox"/>
							Cranial nerves	<input type="checkbox"/>	<input type="checkbox"/>

**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 \_\_\_\_\_