Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, people with intellectual disabilities discover new strengths and abilities, skills and success. Our athletes find joy, confidence and fulfillment — on the playing field and in life. They also inspire people in their communities and elsewhere to open their hearts to a wider world of human talents and potential.

To register to become a Special Olympics athlete, please complete the enclosed forms:

- **PARTICIPANT RELEASE FORM.** Please read the form, print the participant’s name, sign, and date. (You will only need to complete and sign this form once if you are 18 years of age or older)

- **ATHLETE MEDICAL FORM.** The Special Olympics Athlete Medical Form is designed to identify health concerns that are more common among people with intellectual disabilities. Please complete the Health History section on pages 1 and 2. If you do not understand any parts of the form, you may leave those parts blank. Please sign at the bottom of page 2. Page 3 of the Athlete Medical Form should be completed, signed and dated by a medical professional. The Athlete Medical form must be completed every three years. (A licensed Medical Doctor, licensed Chiropractor, Physician’s Assistant, Registered Nurse Practitioner or Doctor of Osteopathic Medicine can complete and sign the medical form)

The Release Form and the Athlete Medical Form instruct you to complete additional forms in certain uncommon situations. If this applies to you or if you have any other questions, please contact Special Olympics Georgia at (770) 414 – 9390 extension 1122 or kelli.britt@specialolympicsga.org

Please submit registration forms to:

BY MAIL: Special Olympics Georgia
6046 Financial Drive
Norcross, GA 30071

OR

BY EMAIL: Kelli.Britt@SpecialOlympicsGA.org

OR

ONLINE: You can find the new Athlete Medical Form on our website at:

http://www.specialolympicsga.org/become-an-athlete/athletes/

Thank you. We are excited you are part of the Special Olympics Movement!
I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.

2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.

3. ** Overnight Stay.** For some events, I may stay in a hotel, college dorm or someone’s home. If I have questions, I will ask.
   
   - **SOGA Housing Policy** – Special Olympics Georgia (SOGA) usually provides housing for Athletes, Unified Partners and Coaches entered in each State Games. SOGA totals the number of male and female Athletes, Unified Partners and Coaches per agency and assigns room allotments based on those totals. When determining allotted room numbers, SOGA allocates and provides 4 persons of the same gender per room for a Double/Double or King room with a pullout, 2 persons of the same gender per room for a King room and 5 persons of the same gender per room for a Queen/Queen with a pullout. In dorm rooms, SOGA allots one bed per person. Athletes, Unified Partners, Coaches and general volunteers may not share a room with Athletes, Unified Partners, Coaches and general volunteers of the opposite sex.

4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:
   - [ ] I have a religious or other objection to receiving medical treatment.
   - [ ] I consent to emergency medical care, but I do not consent to blood transfusions.

   (If either box is checked, 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, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publicly); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and revise my information. I can ask to limit how my information is used.

7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

**PARTICIPANT NAME (PRINT):**

**PARTICIPANT SIGNATURE** (required if over 18 years old and signing on own behalf)
I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: ____________________________  Date: ____________

**PARENT/GUARDIAN SIGNATURE** (required if under 18 years old or has a legal guardian)
I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Parent/Guardian Signature: ____________________________  Date: ____________

Printed Name: ____________________________________________  Relationship: ____________________________

(You cannot alter this form under any circumstances)
Athlete Information – HEALTH HISTORY

(pages 1 & 2 to be completed by the athlete or parent/guardian/caregiver)

**Must complete all items on this page**

**ATHLETE INFORMATION**

First Name: ____________________________  Middle Name: ____________________________  Last Name: ____________________________

Date Birth (mm/dd/yyyy): ____________  Female: ☐  Male: ☐

Address (Street): ____________________________  Phone: ____________________________  Cell: ____________________________

Address (City, State, Zip): ____________________________  E-mail: ____________________________

Eye color: ____________________________  Ethnicity: ____________________________ (optional)

Athlete Employer, if any: ____________________________

I am my own guardian. ☐ Yes  ☐ No

Does the athlete have (check any that apply):

☐ Autism  ☐ Down syndrome  ☐ Fragile X Syndrome

☐ Cerebral Palsy  ☐ Fetal Alcohol Syndrome

☐ Other syndrome, please specify: ____________________________

Is the athlete allergic to any of the following (please list):

☐ Latex  ☐ No Known Allergies

☐ Medications: ____________________________

☐ Insect Bites or Stings: ____________________________

☐ Food: ____________________________

List any special dietary needs: ____________________________

List all past surgeries: ____________________________

Does the athlete currently have any chronic or acute infection? ☐ No  ☐ Yes  If yes, please describe: ____________________________

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? ☐ Yes, had abnormal EKG  ☐ Yes, had abnormal Echo

**PARENT/GUARDIAN INFORMATION** (if not own guardian)

Name: ____________________________  Phone: ____________________________  Cell: ____________________________

E-mail: ____________________________  Emergency Contact Name: ____________________________  Same as Above: ☐ Yes  ☐ No

Emergency Contact Phone (cell): ____________________________  Emergency Contact Relationship: ____________________________

Does the athlete have a primary care physician? ☐ Yes  ☐ No  If yes, list.

Physician Name: ____________________________  Physician Phone: ____________________________

Insurance Policy (Company and Number): ____________________________

Does the athlete have any objections to emergency medical care? ☐ No  ☐ Yes  If yes, contact your local Program to get the Emergency Care Refusal Form.

LIST ANY SPORTS THE ATHLETE WISHES TO PLAY:

Has a doctor ever limited the athlete’s participation in sports? ☐ No  ☐ Yes  If yes, please describe: ____________________________

Does the athlete use: (check any that apply):

☐ Brace  ☐ Colostomy  ☐ Communication Device

☐ C-PAP Machine  ☐ Crutches or Walker  ☐ Dentures

☐ Glasses or Contacts  ☐ G-Tube or J-Tube  ☐ Hearing Aid

☐ Implanted Device  ☐ Inhaler  ☐ Pacemaker

☐ Removable Prosthetics  ☐ Splint  ☐ Wheel Chair

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No  ☐ Yes

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No  ☐ Yes

Has any family member or relative died while exercising? ☐ No  ☐ Yes

List all medical conditions that run in the athlete’s family: ____________________________
**Health History**

**Athlete’s Name:**

**Has the athlete ever been diagnosed with or experienced any of the following conditions?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular, racing or skipped heart beats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Valve Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Murmur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocarditis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowels or bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs, arms, hands or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs, arms, hands or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Head Tilt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spasticity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

**Epilepsy or any type of seizure disorder**

If yes, list seizure type:

<table>
<thead>
<tr>
<th>Type of Seizure</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, had seizure during the past year:

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Self-injurious behavior during the past year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Aggressive behavior during the past year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Depression (diagnosed)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Anxiety (diagnosed)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Please list any medication, vitamins or dietary supplements below**

<table>
<thead>
<tr>
<th>Medication, Vitamin or Supplement</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Medication, Vitamin or Supplement</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Medication, Vitamin or Supplement</th>
<th>Dosage</th>
<th>Times per Day</th>
</tr>
</thead>
</table>

Is the athlete able to administer his or her own medications? | Yes | No |

If female athlete, list date of last menstrual period:

Name of Person Completing this Form | Relationship to Athlete | Phone | Email
ATHLETE'S NAME: 

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI (optional)</th>
<th>Temperature</th>
<th>Pulse</th>
<th>O2Sat</th>
<th>Blood Pressure</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>cm</td>
<td>kg</td>
<td>BMI</td>
<td></td>
<td>C</td>
<td>F</td>
<td>BP Right</td>
<td>No</td>
</tr>
<tr>
<td>in</td>
<td>lbs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BP Left</td>
<td>No</td>
</tr>
</tbody>
</table>

ATLANTO-AXIAL INSTABILITY (AAI)

- Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlantoaxial instability.
- Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

RECOMMENDATIONS (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 use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance.

- This athlete is ABLE to participate in Special Olympics sports without restrictions/limitations
- This athlete is ABLE to participate in Special Olympics sports WITH restrictions/limitations
- This athlete MAY NOT participate in Special Olympics sports at this time and MUST be further evaluated by a physician for the following concerns:

Concerning Cardiac Exam
- Acute Infection
- Stage II Hypertension or Greater
- O2 Saturation Less than 90% on Room Air
- Hepatomegaly or Splenomegaly

Concerning Neurological Exam

Other, please describe:

ADDITIONAL LICENSED EXAMINER’S NOTES AND RECOMMENDED FOLLOW-UP:

- Follow up with a cardiologist
- Follow up with a neurologist
- Follow up with a primary care physician
- Follow up with a vision specialist
- Follow up with a hearing specialist
- Follow up with a dentist or dental hygienist
- Follow up with a podiatrist
- Follow up with a physical therapist
- Follow up with a nutritionist
- Follow up with a nutritionist

LICENSED MEDICAL EXAMINER’S SIGNATURE: ____________________________

DATE OF EXAM: ________________

NAME: _________________________

E-MAIL: _______________________

PHONE: _______________________

LICENSE: ______________________