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 and signed by a medical professional. (A licensed Medical Doctor, 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 119 or matt.sheridan@specialolympicsga.org

Please submit registration forms to:

BY MAIL: Special Olympics Georgia
4000 Dekalb Technology Parkway
Building 400 Suite 400
Atlanta, GA 30340

OR

BY EMAIL: Matt.Sheridan@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 publically); 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**

First Name: 
Middle Name: 
Last Name: 
Date Birth (mm/dd/yyyy): 
Female: ☐ Male: ☐
Address (Street): 
Address (City, State, Zip): 
Phone: 
Cell: 
E-mail: 
Emergency Contact Name: 
Same as Above: ☐
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: 

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

Name: 
Phone: 
Cell: 
E-mail: 

Emergency Contact Name: 
Same as Above: ☐
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. 
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Has any family member or relative died while exercising? ☐ No ☐ Yes 
List all medical conditions that run in the athlete’s family: 

**REGION/AREA/COUNTY:** 

**DELEGATION/TEAM/AGENCY:** 

*Must complete all items on this page*
List any other ongoing or past medical conditions:

- Loss of Consciousness
- Dizziness during or after exercise
- Headache during or after exercise
- Chest pain during or after exercise
- Shortness of breath during or after exercise
- Irregular, racing or skipped heart beats
- Congenital Heart Defect
- Heart Attack
- Cardiomyopathy
- Heart Valve Disease
- Heart Murmur
- Endocarditis

Difficulty controlling bowels or bladder
- If yes, is this new or worse in the past 3 years?

Numbness or tingling in legs, arms, hands or feet
- If yes, is this new or worse in the past 3 years?

Weakness in legs, arms, hands or feet
- If yes, is this new or worse in the past 3 years?

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet
- If yes, is this new or worse in the past 3 years?

Head Tilt
- If yes, is this new or worse in the past 3 years?

Spasticity
- If yes, is this new or worse in the past 3 years?

Paralysis
- If yes, is this new or worse in the past 3 years?

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:

Self-injurious behavior during the past year

Aggressive behavior during the past year

Depression (diagnosed)

Anxiety (diagnosed)

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

Please list any medication, vitamins or dietary supplements below (includes inhalers, birth control or hormone therapy):

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

If female athlete, list date of last menstrual period:

Name of Person Completing this Form  Relationship to Athlete  Phone  Email
Clubbing
Cyanosis
Left
Right
Lungs
Heart
Heart
Lymph
Thyroid
Left Tympanic
Ear
Hearing
Symmetry
Edema
Canal
Ear
Hearing
Symmetry
Edema
Canal
Left
Right

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.

- 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.

**ATLANTO-AXIAL INSTABILITY (AAI)**

- 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

  Concerning Neurological Exam
  - O2 Sat Less than 90%
  - Hepatomegaly or Splenomegaly

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

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

**LICENSED MEDICAL EXAMINER’S SIGNATURE:**

Name: ____________________________
E-mail: ___________________________
Phone: ___________________________
License: __________________________

**DATE OF EXAM:** ___________________________