SPECIAL OLYMPICS OHIO APPLICATION FOR PARTICIPATION

Revised 2/2008

PLEASE PRINT

DEMOGRAPHICS

COUNTY **Clermont** SCHOOL DISTRICT / AGENCY _____

ORGANIZATION **Clermont County Special Olympics** ☐ Male ☐ Female Date of Birth (mo/day/yr) _____/_____/_____

Athlete's Name _____ Athlete Home Phone # _____

Athlete's Address _____ Email Address ☐Athlete ☐Parent/Guardian (list both if applicable)

City *State* *Zip* _____

Parent/Guardian's Name _____ _____

Parent/Guardian's Address (if different than athlete) _____ Parent Primary Phone # _____

City *State* *Zip* Parent Secondary Phone # _____

Emergency Contact (if other than parent/guardian) _____ Emerg. Contact Primary Ph # _____

Health/Accident Insurance Company _____ Policy # _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No	
☐	☐	Heart disease / heart defect / high blood pressure	☐	☐	Allergy:
☐	☐	Chest pain	☐	☐	Medicines: _____
☐	☐	Seizures / epilepsy/fainting spells	☐	☐	Food: _____
☐	☐	Diabetes	☐	☐	Insect stings/bites: _____
☐	☐	Concussion or serious head injury	☐	☐	Special diet
☐	☐	Major surgery or serious illness	☐	☐	Asthma
☐	☐	Heat stroke / exhaustion	☐	☐	Tobacco use
☐	☐	Blindness / visual problem	☐	☐	Easy bleeding
☐	☐	Contact lenses / glasses	☐	☐	Emotional / psychiatric / behavioral
☐	☐	Hearing loss / hearing aid	☐	☐	Sickle cell trait or disease
☐	☐	Bone or joint problem	☐	☐	Immunizations up to date
			☐	☐	Other (For additional space, use back of form): _____

Date of most recent tetanus immunization _____/_____/_____ _____

If the local program has a reasonable basis for believing that there has been a significant change in the athlete's health since this history and physical examination, then the athlete shall be required to seek medical advice & submit a new application form before further Special Olympics participation.

Medications: Please print medication name, amount, date prescribed and number of times per day medication is given. Attach separate sheet if necessary.

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

Signature of parent/caregiver/adult athlete: _____ Date _____/_____/_____

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer).

Yes	No	
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done?
☐	☐	If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Blood pressure: _____/_____ Weight: _____ Height: _____

Normal/Abnormal			Normal/Abnormal			Normal/Abnormal		
☐	☐	Vision	☐	☐	Cardiovascular system	☐	☐	Cranial nerves
☐	☐	Hearing	☐	☐	Respiratory system	☐	☐	Coordination
☐	☐	Oral cavity	☐	☐	Gastrointestinal system	☐	☐	Reflexes
☐	☐	Neck	☐	☐	Genitourinary system	☐	☐	
☐	☐	Extremities	☐	☐	Skin			

Other: _____

Has Mental Retardation? ___Yes ___ No. Primary MR Etiology/Category (If known):_____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics. Any significant change to the above information requires a new examination prior to any participation.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ Date _____/_____/_____

EXAMINER'S NAME: _____

ADDRESS: _____

_____ PHONE: _____