ATHLETE MEDICAL - RELEASE FORM

105 Lakeview Court, Frankfort, KY 40601-8749
(502) 695-8222 or 1-800-633-7403

- PLEASE FILL OUT COMPLETELY -

ATHLETE INFORMATION

NAME ____ NICKNAME ____ SOCIAL SECURITY # ____ - ____ - ____

ADDRESS ____ SEX ☐ M ☐ F DATE OF BIRTH ____ / ____ / ____

CITY/STATE/ZIP ____ PHONE # ( ) -

NAME OF PARENT OR GUARDIAN ____ WHEELCHAIR ATHLETE ☐ Yes ☐ No

ADDRESS ____ PHONE # ( ) -

CITY/STATE/ZIP ____ COUNTY ____

SCHOOL/GROUP ____ COACH ____

Has this individual participated in Special Olympics within the past 5 (five) years? _____ Yes _____ No

EMERGENCY INFORMATION

PERSON TO BE CONTACTED IN CASE OF AN EMERGENCY ____ PHONE # ( ) -

HEALTH AND ACCIDENT INSURANCE INFORMATION

COMPANY NAME ____ POLICY # ____

FOR DOWN SYNDROME ATHLETES ONLY: 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, be 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: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and soccer.

*** This assessment is required only once unless medically indicated otherwise.**

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

Temperature: ______ Pulse: ______ Blood Pressure: ______/______ Weight: ______ Height: ______

ONLY CHECK THE BOXES IF ANY OF THE SYMPTOMS BELOW ARE ABNORMAL.

☐ Vision ☐ Hearing ☐ Oral Cavity ☐ Neck ☐ Extremities ☐ Cardiovascular system ☐ Respiratory system ☐ Gastrointestinal system
☐ Genitourinary system ☐ Skin ☐ Cranial nerves ☐ Coordination ☐ Reflexes

Other: ____________________ PrimaryMR 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. *(Special Olympics is for individuals diagnosed with having an intellectual disability. Refer to Eligibility Statement)*

RESTRICTIONS: ____________________

→ PHYSICIAN/PA/ARNP SIGNATURE: ____________________ DATE ____ / ____ / ____

PHYSICIAN/PA/ARNP NAME (Please Print): ____________________

ADDRESS: ____________________ PHONE # ( ) -

ALL ATHLETES THAT ARE "NEW" TO SPECIAL OLYMPICS KENTUCKY MUST HAVE A PHYSICIAN's, PA's or ARNP's SIGNATURE ON THEIR INITIAL ATHLETE MEDICAL-RELEASE FORM.

HEALTH HISTORY: TO BE COMPLETED BY PHYSICIAN/PA/ARNP/PARENT/CAREGIVER OR ADULT ATHLETE

Specific diagnosis if known: ____________________

	YES	NO
1. Heart Disease/Heart Defect/High Blood Pressure	☐	☐
2. Seizures/Epilepsy/Fainting Spells	☐	☐
3. Down Syndrome	☐	☐
4. Diabetes	☐	☐
5. Concussion or serious head injury	☐	☐
6. Major surgery or serious illness	☐	☐
7. Chest Pain	☐	☐
8. Asthma	☐	☐
9. Blindness	☐	☐
10. Deaf	☐	☐
11. Heat stroke/exhaustion	☐	☐
12. Allergy (list specific)	☐	☐

Medicine ____________________
Foods ____________________
Insect Stings/Bites ____________________
General ____________________

	YES	NO
13. Special diet ____________	☐	☐
14. Tobacco Use	☐	☐
15. Easy bleeding	☐	☐
16. Emotional/psychiatric/behavioral problems	☐	☐
17. Bone or Joint problem	☐	☐
18. Sickle cell trait or disease	☐	☐
19. Hearing aid/hearing loss (CIRCLE)	☐	☐
20. Contact lenses/eyeglasses	☐	☐
21. Hepatitis	☐	☐
22. Immunizations (shots) are up-to-date	☐	☐

23. Date of last tetanus shot_____/_____/_____

A physical examination is required every 3 years for athletes with YES in items 1-8 or NEW PROBLEM in items 1-8. If NO to items 1-8, check the renewal box and no physical examination is required.

☐ **RENEWAL**

MEDICATIONS: Please print medication name, amount, date prescribed and number of times per day medication is given.

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

SPECIAL OLYMPICS KENTUCKY OFFICIAL RELEASE

TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE OR ADULT ATHLETE 18 YEARS OR OLDER

I am the parent/guardian of or am at least 18 years old and my own guardian have submitted the above athlete registration for participation in Special Olympics. I represent and warrant to the best of my knowledge and belief, the above listed person is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in the above registration and has certified, based on either a review of that information, or on an independent medical examination, that there is no medical evidence which would preclude the above person from participating in Special Olympics. I understand that if the above person has Down Syndrome he/she cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on neck or upper spine, unless he/she has had a full radiological examination which established the absence of Atlanto-Axial Instability. I am aware that the above person must have this radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, high jump, alpine skiing, soccer, squat lifts, snowboarding and diving starts in swimming.

Special Olympics has my permission to use the above athlete's likeness, name, voice or words in television, radio, film, newspapers, magazines, and other media, and in any form for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities. I give my consent for the above listed person to participate in any Special Olympics Healthy Athletes Program.

If, during participation in Special Olympics activities, the above athlete should need emergency medical treatment, and I am not able to give my consent to make my own arrangements for treatment, I authorize Special Olympics to take whatever measures are necessary to insure that the athlete receives the emergency medical treatment which Special Olympics deems necessary to protect his or her health and well-being, including hospitalization.

I agree that the information provided on the health history section listed above reflects accurate knowledge on athlete listed.

I, the undersigned, have read and fully understand the provisions of the above release and hereby agree that I will be bound thereby and I shall defend you and hold you harmless of any disaffirmation.

→ SIGNATURE OF PARENT/CAREGIVER/ADULT ATHLETE*(if own legal guardian)*: ____________________ DATE ____ / ____ / ____

WITNESS OF ADULT ATHLETE - If the above release is signed by an adult athlete and explained by another person, complete witness section below. I hereby certify that I have reviewed this release with the adult athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its items.

WITNESS SIGNATURE: ____________________ DATE ____ / ____ / ____

WITNESS NAME (Print) ____________________ RELATIONSHIP TO ATHLETE ____________________