APPLICATION FOR PARTICIPATION (Medical Form)

(must be completed and signed by licensed examiner every 3 years)

(*) (*)
Special Olympics
Mississippi

AREA:				School/Ag	gency:			Λ	Aississippi
SSN://				T-shirt Siz	e: Chile	lren:	OF	R Adult:	
LAST NAME			FIRST				SEX M or F	mont	OF BIRTH h/day/year
Street Number/Address _								/	/
City		State	e	Zip Code		Но	me Phone _	()	
Parent/Guardian									
Address (if different)						Wo	ork Phone_(
City		State	e	Zip Code		Ema	ail address		
Emergency Contact (other									
Health Insurance Compar									
Signature of parent/guard									
FOR ATHLETES WIT									
	erextension. the x-ray evaluation was it positive	on for atlantoa	axial instabilit	ty been dor	ne?				
IS THERE PRESENT O		RY OF (to be	completed b	y parent/o	caregiver):	:			
Chest Pain Seizures/epilepsy/fainting spells Diabetes Hearing aid/hearing problems Blindness/vision problem Yes Major Yes Heat s Yes Easy t Yes Bone/ Sickle		co use surgery or serious illness stroke/exhaustion bleeding joint problems cell disease or trait		☐ Yes	Emotional/psychiatric/behavioral problems Asthma/breathing problems with exertion Contact lenses/glasses/dentures/false teeth Head injury/history of concussion Immunizations (shots) are up-to-date Special Diet Needs (list below) Yes Year of last tetanus shot				
-			wheelchair						
Other problems that woul		n participation	1						
Allergy to the following (
Food					ting/bites _				
Medication			MEDIC						
	<i>'</i>								
Medication Name	Dosage	Date Presc.	Times per day	Med	ication Name		Dosage	Date Presc.	Times per day
Medication Name	Dosage	Date Presc.	Times per day	Med	ication Name		Dosage	Date Presc.	Times per day
Medication Name	Dosage	Date Presc.	Times per day	Med	ication Name		Dosage	Date Presc.	Times per day
Medication Name	Dosage						Dosage	Date Presc.	Times per day
Medication Name		P	Times per day	XAMINA ⁻	TION —		Dosage		
	Noi			XAMINA Normal	TION —		Dosage	No	Times per day
Blood Pressure	Noi Vision U Hearing U	Prmal Abnormal	HYSICAL E	XAMINA Normal	TION	(Cardiovascular Respiratory sys	No system [rmal Abnoma
Blood PressurePulse	Noi Vision Hearing Neck	Prmal Abnormal	Oral Cavity Extremities Coordinati	XAMINA Normal y on	Abnormal	(Cardiovascular Respiratory sys	No system [stem [l.]	rmal Abnoma
Blood PressurePulse	Noi Vision Hearing Neck	Prmal Abnormal	Oral Cavity	XAMINA Normal y	TION		Cardiovascular Respiratory sys	No r system [stem [il system [system [rmal Abnoma
Blood Pressure Pulse Weight	Vision Under the North N	Prmal Abnormal	Oral Cavity Extremities Coordination	Normal y on	Abnormal		Cardiovascular Respiratory sys Gastrointestina Genitourinary s	No r system [stem [il system [system [rmal Abnoma
Blood Pressure Pulse Weight Height Other: Primary MR Etiology/Category	Vision Under the Control of Contr	Prmal Abnormal	Oral Cavity Extremities Coordinati Reflexes	Normal y	Abnormal		Cardiovascular Respiratory sys Gastrointestina Genitourinary s Cranial nerves	No system [] system [] system []	rmal Abnoma
Blood PressurePulseWeightHeight Other:Primary MR Etiology/Category I have reviewed the above health	Vision Grant Not Not Not Not Not Not Not Not Not No	Prmal Abnormal	Oral Cavity Extremities Coordinati Reflexes	Normal y	Abnormal		Cardiovascular Respiratory sys Gastrointestina Genitourinary s Cranial nerves	No system [] system [] system []	rmal Abnoma
Blood PressurePulseWeightHeight Other:Primary MR Etiology/Category I have reviewed the above health preclude the athlete's participati Restrictions	Nor Vision Under the Property of the Property	Prmal Abnormal	Oral Cavity Extremities Coordinating Reflexes	Normal y	Abnormal O O O Indicate the second of th	t there is no	Cardiovascular Respiratory sys Gastrointestina Genitourinary s Cranial nerves	No system (stem (stem (system	rmal Abnoma
Blood Pressure Pulse Weight Height Other: Primary MR Etiology/Category I have reviewed the above health preclude the athlete's participati	Vision Hearing Neck Skin Character of the information and compared to the information and comp	examined the athlepics.	Oral Cavity Extremities Coordinating Reflexes	Normal y	Abnormal	t there is no	Cardiovascular Respiratory sys Gastrointestina Genitourinary s Cranial nerves medical evide	No system (stem (stem (system	rmal Abnoma

OFFICIAL SPECIAL OLYMPICS RELEASE FORM



				nivasiasippi	
AREA:		SCHOO	L/AGENCY:		
ATHLETE NAME:	Last:		First:		
DATE OF BIRTH:	/ / / month day	year			
in Special Olympics ace having an intellectual contained in my (or my evidence which would p (has) Down Syndrome, flexion or direct pressu Release for Athletes w (has) had a a full radic complete the "Special (or my minor child) mu diving, pentathlon, butt Special Olympics has either television, radio,	tivities. I represent the and/or developmental minor child's) applicatoreclude me (or my minor child) re on my for a child result of the child	at I (or my minor child) nal disability. I also repre- tion and has certified, ba- tion child) from participat- cannot participate in spo- r child's) neck or upper s- bility," available from the which establishes the ab- with Atlanto-Axial Instab- tal examination before I arts in swimming, high ju- during and anytime afte agazines, and other med-	neet eligibility requirement(s) for posent that a licensed physician has sed on an independent medical exing in Special Olympics. I understants or events which, by their nature pine unless I and two physicians he Special Olympics Program in my esence of Atlanto-Axial Instability. Ity form which establishes the about (or my minor child) can participate imp, alpine skiing, squat lift and for), to use my (or my minor child's)	likeness, name, voice or words in se of advertising or communicating	
TO BE COMPLETE ADULT ATHLETE			TO BE COMPLETED BY PARENT/GUARDIAN OF		
during my participation in Special Olympics activities, I should need mergency treatment, and I am not able to give my consent or make my wn arrangements for that treatment because of my injuries, I authorize pecial Olympics to take whatever measures are necessary to protect y health and well-being, including, if necessary, hospitalization. Understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form for the safety and health of both myself			If a medical emergency shou participation in any Special Olym personally present so as to be concerby authorize Special Olympersonally are necessary to ensure emergency medical treatment, in	Id arise during the minor athlete's pics activities, at a time when I am not onsulted regarding the athlete's care, I pics, on my behalf, to take whatever re that the athlete is provided with any including hospitalization, which Special ler to protect the minor athlete's health	
and my fellow athletes. I am at least 18 years old for participation in Specific understand the provisions that by signing this paper, release.	I and have submitted the al Olympics. I have rea of the release that I am	e attached application d this paper and fully a signing. I understand	the Athlete Code of Conduct form and health of both my child and t I am the parent/guardian of the n I have read and fully understand thave explained these provisions to	sibility to acquire, review and complete i, with and for my athlete, for the safety heir fellow athletes. ninor athlete named in this application. he provisions of the above release, and to the athlete. Through my signature on to the above provisions on my own	
Signature of Adult Athlete		 Date	behalf and on the behalf of the a	thlete named above. I hereby give my	
signature appears above.	rtify that I have reviewed this release with the athlete whose ppears above. I am satisfied, based on that review, that the erstands this release and has agreed to its terms.			d above to participate in Special ims and physical activity programs.	
Name (print):			Signature of Parent/Guardian	Date	
Relationship to athlete: _					
			nletes at Special Olympics events. Thi ey were made aware that there is a po		