ATHLETE NAME:_____ DATE OF BIRTH: ____ / ____ / ____

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MINNESOTA

Please print clearly and complete all sections in their entirety.
This application expires three (3) years from the date of exam.
People are eligible for Special Olympics provided they are age 8 or above and are considered to have an intellectual disability or closely related developmental disability, defined as functional limitations in both general learning and two or more adaptive skill areas: communication, leisure, self-direction, home living, community use, work, health and safety, academics, self-care and social skills.

State Office ONLY:
Delegation: _____
☐ Updated Form
☐ New Athlete
☐ in GMS
☐ not in GMS

Send completed forms to: SOMN, 100 Washington Ave S., Suite 550, Minneapolis, MN 55401
Email: athletepaperwork@somn.org Fax: 612.333.8782

SECTION A: DEMOGRAPHICS

Delegation: _____

Athlete Name: _____

Athlete Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Parent/Guardian Address
(if different than athlete): _____

City: _____ State: _____ Zip: _____

Emergency Contact
(if other than Parent/Guardian): _____

Emergency Contact
Relationship to Athlete: _____

☐ Male ☐ Female Date of Birth: ____/____/____

Athlete Primary Phone: (_____) _____
(Circle one) home work cell

Athlete Email: _____

Parent Primary Phone: (_____) _____
(Circle one) home work cell

Parent Alternate Phone: (_____) _____
(Circle one) home work cell

Parent Email: _____

Emergency Contact Phone: (_____) _____
(Circle one) home work cell

Health/Accident Insurance Company: _____

Policy #: _____

SECTION B: HEALTH HISTORY (MAY BE COMPLETED BY PARENT/GUARDIAN)

Please indicate "yes" or "no" for all areas

Yes	No	
☐	☐	Allergies: _____
☐	☐	Asthma
☐	☐	Blindness/Visual Problems (other than corrective lenses)
☐	☐	Bone or Joint Problem
☐	☐	Chest Pain
☐	☐	Concussion or Serious Head Injury:_____
☐	☐	Contact Lenses/Glasses
☐	☐	Diabetes
☐	☐	Down Syndrome ***(If Yes, see next page)***
☐	☐	Easy Bleeding
☐	☐	Emotional/Psychiatric/Behavioral Problems
☐	☐	Hearing Loss/Hearing Aid
☐	☐	Heart Disease/Heart Defect/High Blood Pressure
☐	☐	Heat Stroke/Exhaustion
☐	☐	Immunizations up-to-date
☐	☐	Major Surgery or Serious Illness _____
☐	☐	Non-verbal
☐	☐	Seizures/Epilepsy/Fainting Spells
☐	☐	Sickle Cell Trait or Disease
☐	☐	Special Diet _____
☐	☐	Uses Tobacco
☐	☐	Uses Wheelchair
☐	☐	Other: _____

(for additional space, please see reverse side)

☐ ☐ Have you ever been convicted of a criminal offense?*

☐ ☐ Have you ever been charged with neglect, abuse or assault?* (SEE BELOW)

*If yes, providing your Social Security Number:
_____ - ____ - _____ will give Special Olympics Minnesota consent to run a background check.

Medications: ☐ None ☐ Listed Below

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

SIGNATURE • REQUIRED •

Signature of Parent/Guardian _____ Date: ____ / ____ / ____
Required. Athletes can sign if they are their own guardian.

Printed Name _____ Relationship to Athlete _____

ATHLETE NAME:_____ DATE OF BIRTH: _____ / _____ / _____

SECTION C: PHYSICAL EXAMINATION

Must be completed by a licensed medical practitioner

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			

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

Please list intellectual disability: _____

Other: _____

☐ **Yes** ☐ **No** Does this athlete have Down syndrome? Complete the information below.

☐ **Yes** I have reviewed the above health information and have performed the above examination on this athlete within the past six (6) months and certify that the athlete can participate in Special Olympics.

Restrictions: _____

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:** equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and soccer.

Yes	No	
☐	☐	Does the athlete participate in a restricted sport or event? If yes or unknown, an x-ray for atlanto-axial instability must be done.
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done?
☐	☐	If yes, was the x-ray positive for atlanto-axial instability? Positive indication is the atlanto-dens interval is 5mm or more.

Please list any additional information that may be helpful to know about this athlete: _____

_____

_____

_____

THE EXAMINER'S SIGNATURE AND DATE OF EXAM BELOW ARE REQUIRED INFORMATION FOR SECTION C OF THIS APPLICATION TO BE COMPLETE. IF SUBMITTING AN ELECTRONICALLY GENERATED FORM, IT MUST CONTAIN INDICATION OF AN ELECTRONIC SIGNATURE AND THE CONTACT INFORMATION BELOW.

SIGNATURE • REQUIRED • Examiner's Signature:_____ Date of exam: _____ / _____ / _____

Examiner's Name: _____

Clinic Name:_____

Address (City, State, Zip): _____

Phone: (_____) _____

ATHLETE NAME:_____ DATE OF BIRTH: _____ / _____ / _____

OFFICIAL SPECIAL OLYMPICS ATHLETE CONSENT FORM

SECTION A: CONSENT TO BE COMPLETED BY ADULT ATHLETE

☐ I, _____, am at least 18 years old and am my own legal guardian. *Please complete Section A only.*

☐ I, _____, am at least 18 years old but am NOT my legal guardian. *Please complete Section B only.*

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I have submitted the Special Consent for Athletes with Down Syndrome, available from the Special Olympics program in my state, or I have had a full radiological examination which established the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the Special Consent for Athletes with Down Syndrome form which established the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in aquatics, high jump, alpine skiing, snowboarding, squat lift and soccer.

Special Olympics has my permission, (both during and anytime after), to use my likeness, name, voice, or words in either television, radio, film, newspapers, magazines, Web site 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 be used for these purposes and activities.

I understand that the relationship between Special Olympics and me is an "at will" arrangement and such a relationship can be terminated at any time without cause by either Special Olympics or me.

If, during my participation in Special Olympics, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the consent that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this consent.

SIGNATURE •REQUIRED• Signature of Adult Athlete _____ Date: _____ / _____ / _____

SIGNATURE •REQUIRED• Signature of Witnessing Adult _____ Date: _____ / _____ / _____

SECTION B: CONSENT TO BE COMPLETED BY PARENT OR GUARDIAN OF ATHLETE

I am the parent/guardian of _____, on whose behalf I have submitted the attached Application for Participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application, and has certified based on an independent medical examination that there is no medical evidence which would preclude the athlete's participation. I understand that if the athlete 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 the neck or upper spine, unless two physicians and myself have completed the official Special Consent for Athletes with Down Syndrome, available from the Special Olympics program in my state, or the athlete has had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the Special Consent for Athletes with Down Syndrome form which established the absence of Atlanto-Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in aquatics, high jump, alpine skiing and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after), to Special Olympics to use the athlete's likeness, name, voice, and 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.

If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be personally consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

I am the parent/guardian of the athlete named in this application. I have read and fully understand the provisions of the above consent, and have explained these provisions to the athlete. Through my signature on this consent form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

I understand that the relationship between Special Olympics and the athlete is an "at will" arrangement and such a relationship can be terminated at any time without cause by either Special Olympics or the athlete.

I hereby grant my permission for the above named athlete to participate in Special Olympics games, recreation programs and physical activity programs.

SIGNATURE •REQUIRED• Signature of Parent/Guardian _____ Date: _____ / _____ / _____

Printed Name _____ Relationship to Athlete _____

ATHLETE NAME:_____ DATE OF BIRTH: _____ / _____ / _____

HEALTHY ATHLETES CONSENT FORM

Special Olympics Healthy Athletes

Special Olympics, Inc. offers non-invasive health care services to athletes at local, state, national and World Games venues through the Healthy Athletes program. These services have included individual screening assessments of health status and health care needs, provision of health education, routine preventive services (e.g. protective mouth guards), educational services, and, in the case of vision and hearing deficits, provision of needed eyewear (glasses, swim goggles, protective eyewear) and hearing aids. Athletes are informed as to their health status and advised as to the need for follow-up care. In addition, information collected at the time services are provided has been invaluable for developing policies, securing resources and implementing programs to better meet the health needs of athletes.

Such health services will be made available to Special Olympics athletes where offered through Healthy Athletes venues. Services may be offered in the following areas: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). These services will be free of charge and are available to all Special Olympics athletes whether they are competing at the specific Games event or not. The services will be delivered by qualified health professionals who, in addition, have received Special Olympics-provided training. Many of the volunteer health professionals have previous experience in serving Special Olympics athletes and other special needs patients.

AUTHORIZATION FOR MINORS: I authorize the participation of _____ (athlete's full name) in the Healthy Athletes screening venues. I understand that participation in the Healthy Athletes venues is voluntary and that authorization can be withdrawn at any time without penalty and that participation in Healthy Athletes is not a requirement for participating in other Special Olympics activities. I understand that the provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

_____ _____ / _____ / _____

Athlete's Printed Name Date of Birth

_____

Special Olympics Minnesota Delegation

SIGNATURE • REQUIRED • Signature of Parent/Guardian _____ Date: _____ / _____ / _____

For athletes 17 years old and younger

SIGNATURE • REQUIRED • Signature of Athlete _____ Date: _____ / _____ / _____

For athletes 18 years old and older

NOTE: This authorization shall remain effective unless the consenting party requests termination or the scope of the Healthy Athletes program changes materially.