Special Olympics Massachusetts

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

BASIC INFORMATION

Check here if New Athlete ☐ | *Parents/Guardian – Keep a Copy of this* | ***ALL SIGNATURES ARE REQUIRED***

First Name | Last Name | Male ☐ Female ☐

Race Ethnicity (Optional)
☐ Black ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian ☐ Other

Date of Birth ____/____/____

Street Address or PO Box | Apt #

City/Town | State | ZIP Code + 4

Home Phone # or Cell # (circle one) ____-____-____ | Email Address

Parent/Guardian's Name | Home Phone # or Cell # (Circle one) ____-____-____

Emergency Contact (if other than parent/guardian) | Emergency Contact Cell Phone # ____-____-____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Health/Accident Insurance Company _____ Policy # _____

Yes	No		Yes	No	
☐	☐	Heart disease / heart defect / high blood pressure	☐	☐	Allergy:
☐	☐	Chest pain	☐	☐	General: _____
☐	☐	Seizures / epilepsy/ fainting spells	☐	☐	Medicines: _____
☐	☐	Diabetes	☐	☐	Food: _____
☐	☐	Concussion or serious head injury	☐	☐	Insect stings/bites: _____
☐	☐	Major surgery or serious illness	☐	☐	Special diet: _____
☐	☐	Heat stroke / exhaustion	☐	☐	Asthma
☐	☐	Blindness / visual problem	☐	☐	Emotional/psychiatric/behavioral/requires extra supervision
☐	☐	Contact lenses / glasses	☐	☐	Description: _____
☐	☐	Hearing loss / hearing aid			Immunizations up to date
☐	☐	Bone or joint problem			Other: _____
☐	☐	Currently on Medication *(If yes, please bring current list with*	☐	☐	Down syndrome **(see below)**
☐	☐	*you to each competition)*	☐	☐	Date of most recent tetanus immunization____/____/____

PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER

Primary ID Etiology/Category: (If known) _____

I have reviewed the above health information and have performed the above examination on this athlete and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

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

(*no office stamps accepted without provider's signature)*

Examiner's Name

Street Address or P.O.

City/Town | State | ZIP | Phone # ____-____-____

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: SOMA requires persons with Down syndrome to have 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.

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

Last Name, First Name:

Form Expiration Date ____/____/____

A copy of this application must be with your coach at all trainings and Competitions, and filed/sent to SOMA's Office:
512 Forest Street, Marlborough, MA 01752 | Fax: 508-481-0786 | Email: Ops@SpecialOlympicsMA.org

Special Olympics Massachusetts

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

ATHLETE RELEASE: TO BE COMPLETED BY ATHLETE OVER 18, OR PARENT/GUARDIAN OF MINOR ATHLETE

For Athletes over 18 years old:
I the athlete, named above, have read the Athlete Release Form (below) and fully understand the provisions of the release that I am signing. I understand that by signing this, I am saying that I agree to the provisions of the release

Signature of adult athlete (over 18): **Date:** _____/_____/_____

For Parent/Guardian of Athlete:

I hereby certify that I have reviewed this release with the Athlete whose signature appears above. I am satisfied based on that review that the athlete understands the release and has agreed to its terms

Print Name: **Relationship to athlete:** **Date:**

For Parent/Guardian of Athlete under 18 years old

I am the parent (guardian) of the Athlete named in this application. I have read and fully understand the provisions of the Athlete Release Form (below), and have explained these provisions to the Athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the Athlete named above. I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Guardian (for athlete under 18): **Date:** _____/_____/_____

ATHLETE RELEASE FORM

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 medical professional has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence that 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 and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction, or I have had a full radiological examination that establishes the absence of Atlanto-axial Instability (see box on page 1). I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer).

Special Olympics has my permission forever to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program 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. I understand there is no obligation for me to participate in the Healthy Athletes Program and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment for any reason, I authorize Special Olympics to take whatever measures it deems necessary to protect my health and well-being, including, if necessary, hospitalization. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT FORM)**

BROOKLINE SPECIAL OLYMPICS HEALTH FORM

ATHLETE NAME: _____ **EMAIL:** _____

PRIMARY DISAGNOSIS:

_____Autism _____Down Syndrome _____Intellectual Disability (ID) _____Cerebral Palsy _____ Spina Bifida
_____Emotional/Behavioral (ADHD) _____Spinal Cord Injury _____Head/Brain Injury _____Visual Impairment
_____Hearing Impairment _____Other (Please Explain)_____

SECONDARY DISAGNOSIS: (Please Specify any other Disabilities/Diagnosis)_____
_____

MEDICATION REGIMENT: Please list all medications currently being taken.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES: Please list all allergies the athlete has. (food, medicine, environmental, etc.)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

INDICATIONS OF PREVIOUS SURGERIES/OTHER IMPORTANT HEALTH EVENTS (CONTINUE ON BACK IF NEEDED)

_____
_____
_____
_____

IN THE EVENT OF AN EMERGENCY, IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THIS ATHLETE?

_____
_____
_____
_____

EMERGENCY CONTACT 1: _____
NAME NUMBER

EMERGENCY CONTACT 2: _____
NAME NUMBER

SIGNATURE: _____ **DATE:** _____

THIS FORM IS UPDATED SEASONALLY AND MUST BE TURNED IN TO PROGRAM COORDINATOR BY _____.

Acknowledgement Form

By signing below, I acknowledge that I have received and agree to follow the SOMA Athlete Code of Conduct.

Signature: _____ Date: _____

Signature of parent /guardian if under 18: _____ Date: _____

One of the goals of SOMA Brookline Chapter is to encourage team commitment. For this reason athletes will be expected to attend at least 75% of practices to participate in tournaments. Athletes should notify coaches or program coordinator if unable to attend practice.

By signing below, I acknowledge that I have read and agree to attend at least 75% of practices. If I am unable to attend practice, I will notify my coach or program coordinator.

Signature: _____ Date: _____

Signature of parent/guardian if under 18: _____ Date: _____

Please contact Justine Carey, Recreation Specialist with any questions.

Email: jcarey@brooklinema.gov Phone: 617-879-4794

BROOKLINE
Recreation Therapy

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